HealthTrust

Medicomp Three Subscriber Certificate

What You Need to Know about Your Health Care Plan for Retirees

Anthem BlueCross BlueShield

14407NH (7/2021) **Rev. (1/2023)**

Welcome!

Your medical coverage is provided through an arrangement between HealthTrust and Anthem Blue Cross and Blue Shield (Anthem). You also have access to HealthTrust's Slice of Life wellness program, providing resources and rewards for making positive lifestyle choices.

To Get the Most Out of Your Plan - take a minute to create your own secure online account at *www.healthtrustnh.org*. Click "Secure Login" on the homepage, then "New User." Your secure account will give you access to information and resources not available to the general public, as well as direct links to our vendor partner sites to participate in a variety of valuable programs.

How to Get Language Assistance – HealthTrust and Anthem are committed to communicating with you about your Plan, no matter what your language is. Anthem provides a language line interpretation service for use by you and your covered family members. Simply call Anthem Member Services at the telephone number on your identification card and a representative will be able to help you. Translation of written materials about your Benefits can also be asked for by contacting Anthem Member Services. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with your needs.

If you have questions, please contact HealthTrust or Anthem during business hours.

To call us:
HealthTrust Enrollee Services: 1-800-527-5001

Anthem Member Services: See the number on your identification card

To write us:
HealthTrust
PO Box 617
Concord, NH 03302-0617

Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660

To visit us:
HealthTrust
25 Triangle Park Drive
Concord, NH

To visit our website:
HealthTrust: *www.healthtrustnh.org*

Anthem: *www.anthem.com*

Thank you for the privilege to serve your health plan needs and to help you live your healthiest life.

Wendy Lee Parker
Executive Director
HealthTrust, Inc.

Maria M. Proulx
President and General Manager
Anthem Blue Cross and Blue Shield, New Hampshire

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INTRODUCTION

Please see Section 11 for Definitions of specially capitalized words.

This Medicomp Three Subscriber Certificate describes the terms and conditions of the Medicare Complementary Benefits and Major Medical Benefits provided under HealthTrust's Medicomp Three health care plan (the "Plan"). Your Group is making the Plan available to You and other eligible Retirees as an important benefit. This Certificate describes the Benefits available under the Plan as well as Your rights and responsibilities, including procedures You must follow. Benefits are provided and funded by HealthTrust, Inc. ("HealthTrust"), while Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield ("Anthem"), provides certain administrative services, including claims processing.

Except for those services which are paid or payable by Medicare, HealthTrust has sole and exclusive discretion in interpreting coverage and Benefits available under the Plan including the terms, conditions, limitations and exclusions set forth in this Certificate, and in making factual determinations related to Benefits. HealthTrust may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Plan (for example, Anthem). Examples of such delegation of discretionary authority appear in this Certificate where HealthTrust provides Anthem the right to make the final determination of Benefits for Covered Services. Any change or amendment to the Plan or this Certificate must be made in writing and must be duly adopted by HealthTrust. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. HealthTrust further reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

HealthTrust may, in its sole discretion, arrange for various persons or entities (for example, Anthem) to provide administrative services in regard to the Plan, including claims processing. The identity of the service Provider and the nature of the services provided may be changed from time to time, at the sole discretion of HealthTrust, and without prior notice to or approval by Groups or Members.

SECTION 1: HOW YOUR PLAN WORKS – GENERAL INFORMATION

Please see Section 11 for Definitions of specially capitalized words.

I. About This Certificate

This is Your Medicomp Three Subscriber Certificate. It describes the relationship among You, Your health care Providers, Your Group and the Plan. You are entitled to the Benefits described in this Certificate provided that all conditions for membership described in Section 10 have been met. Certain rights and responsibilities are also described in this Certificate. Please read Your Certificate carefully because it explains the terms of Your coverage.

HealthTrust may issue riders or endorsements that amend this Certificate by describing additional Covered Services or limitations.

II. About Your Coverage

Your Medicomp Three coverage includes Medicare Complementary Benefits and Major Medical Benefits.

Medicare Complementary Benefits are available as a complement to benefits which are paid or payable by Medicare. Covered Services for Medicare Complementary Benefits are determined based upon policies and rules published by Medicare. Medicare Complementary Benefits and cost sharing are described in Section 2.

Major Medical Benefits are Benefits which are in addition to Your Medicare Complementary Benefits. Coverage for Major Medical Benefits is determined by HealthTrust and Anthem as set forth in this Medicomp Three Certificate. Major Medical Benefits and cost sharing are described in Section 4. Major Medical Benefit limitations and exclusions are described in Section 5.

III. Providers

For purposes of Medicare benefits, Providers elect to accept or not accept Medicare assignment. To receive the maximum level of Medicare benefits, You need to use a Provider who accepts Medicare assignment.

For purposes of Your Medicare Complementary Benefits and Major Medical Benefits, Participating Providers have a written agreement with Anthem to provide Covered Services to Members. These agreements may include financial incentives or risk-sharing relationships related to provision of services or referrals to other Providers. These financial incentives for cost-effective care are consistent with generally recognized professional standards. If You have questions regarding such incentives or risk-sharing relationships, please contact Your Provider or Anthem. Participating Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care.

For purposes of Your Major Medical Benefits, Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or Member Services duties on Anthem's behalf.

Participating Providers who have a written agreement with Anthem are listed in the Participating Provider directory. Since the directory is updated periodically, it may not always be current at the time You need to arrange for Covered Services. To locate the most up-to-date information about Participating Providers, You are encouraged to go to Anthem's website, www.anthem.com. You may contact Anthem Member Services for assistance at the telephone number on Your identification card.

IV. Group Coverage

You are covered under this Certificate as part of a Group. Eligibility rules are determined by Your Group and HealthTrust. By submitting Your signed Medical Enrollment Application and by making or authorizing Your Group to make premium payments to HealthTrust on Your behalf, You agree to the terms of this Certificate. Provided that the required premium is paid on time, Your coverage becomes effective on a date determined by Your Group and by HealthTrust as described in Section 10, II.

V. Services Must be Medically Necessary

Each service that You receive must be Medically Necessary. Otherwise, no Benefits are available. The definition of Medically Necessary is stated in Section 11. Medicare and Anthem may have different policies or rules that are used to determine whether services You receive are Medically Necessary. Medicare's Medical Necessity policies and rules are used to determine whether services are paid or payable under Medicare Part A or Part B and are eligible for Medicare Complementary Benefits. Anthem's Medical Necessity policies and rules are used to determine whether services are covered under the Major Medical Benefits provided in this Medicomp Three Certificate.

Anthem is given the right to review services to be covered under Your Major Medical Benefits after the services have been furnished in order to confirm that they were Medically Necessary. If the services of a Participating Provider are later determined to be not Medically Necessary, the Participating Provider is prohibited from billing You for the portion of services that would have been covered if they had been Medically Necessary unless You have otherwise agreed in writing before You receive the services. You are responsible for the full cost of services provided by a Nonparticipating Provider that Anthem determines to be not Medically Necessary.

VI. No Preexisting Condition Exclusion

HealthTrust does not apply or enforce any preexisting condition exclusions with respect to Your coverage under the Plan.

VII. Contact Information for HealthTrust and Anthem

If You have any questions about Your health Plan coverage or Benefits available under this Certificate, please call or write to HealthTrust or Anthem at the locations listed below. All correspondence with HealthTrust or Anthem should include Your Group name and number, Your identification number and Your telephone number.

Contact HealthTrust at:
HealthTrust
PO Box 617
Concord, NH 03302-0617
Telephone Number: 603-226-2861 or 1-800-527-5001

Contact Anthem at:
Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660
Member Services Telephone Number: See Your identification card

SECTION 2: MEDICARE COMPLEMENTARY BENEFITS

Please see Section 11 for Definitions of other specially capitalized words.

This Section describes the Medicare Complementary Benefits available under the Plan. Medicare Complementary Benefits generally satisfy those amounts that remain after Medicare has made payment for Medicare Eligible Expenses, for example Medicare Part A and Part B Deductibles and Medicare Coinsurance. Please also refer to the Medicare Complementary Benefits Cost Sharing Schedule at the end of this Section.

Please note: If You exhaust or exceed any Medicare or Medicare Complementary Benefits limitations or maximums or You incur expenses for services that are not Medicare Eligible Expenses, You may be entitled to Major Medical Benefits provided under this Certificate. Please refer to Sections 3, 4 and 5 for information about Major Medical Benefits.

I. Medicare Part A (Inpatient Hospital and Skilled Nursing Home Services)

Medicare Part A Deductible
Each calendar year, Medicare requires payment of the Medicare Part A Deductible before Medicare pays for Medicare Part A expenses. Your Medicare Complementary Benefits cover in full the Medicare Part A Deductible.

Hospital Inpatient Services
Medicare Part A requires payment of Medicare Part A Coinsurance during hospital stays beginning on the 61st day through the 90th day in a Medicare Benefit Period. Your Medicare Complementary Benefits cover in full the Medicare Part A Coinsurance for the 61st day through the 90th day.

Medicare Part A requires payment of Medicare Part A Coinsurance during hospital stays when using Medicare's 60 lifetime reserve days. Your Medicare Complementary Benefits cover in full the Medicare Part A Coinsurance for the 60 lifetime reserve days.

If Medicare Part A hospital benefits, including the 60 lifetime reserve days, are exhausted, Your Medicare Complementary Benefits then cover 90% of Medicare Eligible Expenses for hospital Inpatient services up to a lifetime maximum of 365 days.

Skilled Nursing Facility Services
Medicare Part A covers in full Medicare Eligible Expenses received in a semi-private room in a skilled nursing facility during the first 20 days of confinement. Medicare Part A requires payment of Medicare Part A Coinsurance beginning on the 21st through the 100th day of confinement. Your Medicare Complementary Benefits cover in full the Medicare Part A Coinsurance for the 21st day through the 100th day of confinement in a skilled nursing facility. Generally, Skilled Nursing Facility confinement must follow a Medicare approved hospitalization of 3 or more days.

Hospice Care
Medicare Part A covers in full Medicare Eligible Expenses for hospice care. Medicare Part A requires payment of Medicare Part A Coinsurance for Outpatient prescription drugs and Medicare-approved Inpatient respite care. Your Medicare Complementary Benefits cover in full the Medicare Part A Coinsurance for Outpatient prescription drugs and Inpatient respite care.

Home Health Care
Medicare Part A requires payment of certain Medicare Part A Coinsurance amounts for home health care. Your Medicare Complementary Benefits cover in full the Medicare Part A Coinsurance for home health care.

Medicare Part A Blood
Medicare Part A will cover Medicare Eligible Expenses for all but the first 3 pints of blood when You are an Inpatient. Your Medicare Complementary Benefits cover in full the cost of the first 3 pints of blood.

II. Medicare Part B (Physician and Outpatient Hospital Services)

Medicare Part B Deductible
Each calendar year, Medicare requires payment of the Medicare Part B Deductible before Medicare pays for Medicare Part B expenses. Your Medicare Complementary Benefits cover in full the Medicare Part B Deductible.

Medical Services
Medicare Part B covers Medicare Eligible Expenses for services provided by physicians and other Medicare approved providers, including independent laboratories, ambulance services, and independent physical therapists. Some Outpatient hospital services are also covered under Medicare Part B.

Medicare Part B requires payment of Medicare Part B Coinsurance for certain Medicare Part B services. Your Medicare Complementary Benefits cover in full the Medicare Part B Coinsurance.

Medicare Part B Blood
Medicare Part B will cover Medicare Eligible Expenses for all but the first 3 pints of blood when You are an Outpatient. Your Medicare Complementary Benefits cover in full the cost of the first 3 pints of blood.

Outpatient (non-Hospital) Treatment of Mental Health Conditions
Medicare Part B requires payment of a percentage of the Medicare Eligible Expenses for Outpatient mental health care. Your Medicare Complementary Benefits cover in full the percentage of the Medicare Eligible Expenses not covered by Medicare Part B.

Outpatient (non-Hospital) Physical, Speech and Occupational Therapy
Medicare Part B requires payment of Medicare Part B Coinsurance for Outpatient physical, speech or occupational therapy. Your Medicare Complementary Benefits cover in full the Medicare Part B Coinsurance for physical, speech or occupational therapy.

III. Medicare Complementary Benefits – Cost Sharing Schedule

MEDICARE PART A BENEFITS	MEDICARE PART A PAYS	MEDICARE COMPLEMENTARY BENEFITS PAY	REMAINING BALANCE*
INPATIENT HOSPITAL BENEFITS			
First 60 days of Medicare Benefit Period	Full cost after Medicare Part A Deductible	Medicare Part A Deductible	None
Next 30 days (61st through 90th days)	Full cost except for Medicare Part A Coinsurance	Medicare Part A Coinsurance	None
Next 60 days of one-time Lifetime reserve days (91st through 150th days)	Full cost except for Medicare Part A Coinsurance	Medicare Part A Coinsurance	None

After 150 days of confinement	Nothing	90% of Covered Services; Lifetime Maximum: 365 days	Remaining 10%; 100% after 365 days
Blood	Full cost after 3 pints	First 3 pints of blood	None
SKILLED NURSING HOME BENEFITS	*Caution*: You should check to see if the facility qualifies for Medicare. ** **REMEMBER**: Skilled Nursing Home confinement must follow a hospitalization and be medically necessary. *CUSTODIAL CARE IS NOT COVERED.*		
First 20 days of confinement	Full Cost	Nothing	None
Next 80 days (21st through 100th days)	Full cost except for Medicare Part A Coinsurance	Medicare Part A Coinsurance	None
After 100 days of confinement	Nothing	Nothing	100% after 100 days
MEDICARE PART B BENEFITS	**MEDICARE PART B PAYS**	**MEDICARE COMPLEMENTARY BENEFITS PAY**	**REMAINING BALANCE***
MEDICAL SERVICE BENEFITS			
Physician Services, Hospital Outpatient, Prosthetic Devices, Durable Medical Equipment, Immunosuppressive Drugs and Other Covered Services	Medicare Eligible Expenses after Medicare Part B Deductible and Medicare Part B Coinsurance	Medicare Part B Deductible and Medicare Part B Coinsurance	100% of non-Medicare Eligible Expenses
Blood	Full cost after 3 pints	First 3 pints of blood	None
Non-inpatient Psychiatric Services (Please refer to the "Medicare and You" Handbook for psychiatric maximums and exceptions.)**	80% of Medicare Eligible Expenses after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare Eligible Expenses	100% of non-Medicare Eligible Expenses

* Any remaining balance for a Covered Service may be eligible for coverage under the Major Medical Benefits provided under this Medicomp Three Certificate. Please refer to Sections 3, 4 and 5 for information about Major Medical Benefits.

** For information about Medicare, go to www.medicare.gov on the web, select "What Medicare Covers." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION 3: ABOUT MAJOR MEDICAL BENEFITS

Please see Section 11 for Definitions of specially capitalized words.

Your Major Medical Benefits under this Plan have Certain Requirements. This means that when You receive certain Major Medical Covered Services, Anthem (or a designated administrator) works with You and Your health care Providers to determine if You are receiving Medically Necessary services.

A Member's right to Major Medical Benefits under the Plan is subject to certain clinical policies and administrative procedures. Clinical policies are used by Anthem to determine Major Medical Benefits and include such things as Anthem's medical policies and utilization review criteria. You may obtain information about these policies by contacting Anthem. Administrative procedures include such things as concurrent review and care management. A description of these procedures is provided in this Section and elsewhere in this Certificate.

None of Anthem's employees or the Providers that Anthem contracts with to make medical management decisions are paid or provided incentives to deny or withhold Benefits for services that are Medically Necessary and are otherwise covered. In addition, Anthem requires members of its clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying Benefits for services that are Medically Necessary and are otherwise covered.

Your Plan requires that Covered Services be Medically Necessary for Benefits to be provided. To determine Medical Necessity, Your Plan includes the processes of pre-service, concurrent and retrospective reviews to determine when services should be covered by the Plan. The purpose of these processes is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

The following provisions pertain only to coverage for Your Major Medical Benefits:

I. Your Role

You play an important role in this Medicomp Three Plan. As a Member, You should become familiar with and follow Plan rules and procedures. These are described throughout this Certificate. Knowing and following Plan rules and procedures is the best way for You to enjoy all of the advantages of Your Major Medical Benefits.

Anthem wants to know if You have a concern about the quality of care offered to You by a Participating Provider (such as waiting times, Provider behavior or demeanor, adequacy of facilities or other similar concerns). You should discuss Your concerns directly with the Provider, but Anthem also would appreciate knowing about Your experience. Your suggestions are important to Anthem. Please contact Anthem Member Services at the number on Your identification card with Your suggestions.

You can appeal any decision Anthem makes about Your Major Medical Benefits. Please see Section 8 for information about how to use the appeal procedure.

II. The Role of Participating Providers

Participating Providers will work together to make sure that You have access to the health care services that You need. Your Participating Provider can best oversee and coordinate Your care if You choose to contact him or her before You receive health care services.

Most often, Your Participating Provider will provide Your routine or urgent care directly. If Your Provider determines that You require specialized care that falls outside his or her clinical expertise or services offered, Your Provider will refer You to another Provider. With few exceptions, You will be referred to a Participating Provider.

III. The Role of Anthem

As the administrator of Benefits under this Plan, Anthem's Medical Director and Medical Services Division play an important role in the management of Your Benefits. Some examples are:

A. Prior Approval. At Your Provider's request, Anthem will review proposed services to determine if the service is a Covered Service. For example, if Your Provider proposes a surgery that may be considered cosmetic or dental (and therefore not covered), he or she must submit clinical information for review *before* You receive the service.

B. Determinations about Medical Necessity. Anthem is given the right to make determinations about whether or not a Major Medical Benefits service is Medically Necessary. Please see Section 11 for a definition of "Medically Necessary."

Please note:

- For Major Medical Benefits, Anthem will use its own standards for determining Medical Necessity and Experimental or Investigational services, not Medicare's.

- Anthem's Medical Policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Medical Policy is to assist in Anthem's determination of Medical Necessity. However, the Benefits, exclusions and limitations described in this Certificate take precedence over Medical Policy. Medical technology is constantly changing and Anthem reserves the right to review and update Medical Policy periodically.

C. Determinations about Experimental or Investigational Services. Anthem is given the right to make determinations about whether or not a service is Experimental or Investigational. Please see Section 5, I, B for a definition of "Experimental or Investigational Services."

D. Review of New Technologies. Anthem is given the right to make final determinations about coverage for new technologies. Medical technology is constantly changing and Anthem reserves the right to review and update Medical Policy periodically regarding coverage for new technologies. Anthem evaluates new medical technologies to define medical efficacy and to determine appropriate coverage. Anthem's evaluations are focused on the following factors:

- The technology must have final approval from the appropriate governmental regulatory bodies.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.

- The technology must improve net health outcomes.

- The technology must be as beneficial as any established alternatives.

- The improvement must be attainable outside the Investigational setting.

E. Individual Case Management. Anthem maintains case management programs that tailor services to the individual needs of Members and seek to improve the health of Members. Case management is Anthem's process of evaluating and arranging for Medically Necessary treatment for Members identified as being eligible for individual case management. Participation in case management programs is voluntary.

Anthem's case managers are registered nurses and other qualified health professionals who work collaboratively with the Member, the Member's family and Providers to coordinate the Member's healthcare Benefits. In certain extraordinary circumstances involving intensive case management, Anthem is given the right to provide Benefits for care that is Medically Necessary but not listed as a Covered Service in this Certificate. Anthem also is given the right to extend Benefits for Covered Services beyond the Benefit maximums stated in this Certificate. Decisions regarding case management are made on a case-by-case basis. By providing services through case management, the Plan makes exception only for a specific case and is not committed to providing similar coverage and Benefits again for You, nor for other Members. All other terms and conditions of this Certificate shall be strictly administered.

Anthem is given the right to alter or discontinue case management when it is no longer Medically Necessary. The Member or the Member's representative shall be notified in writing of alterations or a discontinuation of case management. Members who disagree with Anthem's determination may utilize the appeal procedure described in Section 8.

IV. Important notes about this Section

Benefits are not guaranteed by Your Provider's order or Prior Approval. Benefits are subject to all of the terms and conditions of the Certificate in effect on the date You receive services.

Anthem's decisions about Prior Approval requests, Medical Necessity, Experimental or Investigational services and new technologies are not arbitrary. Anthem's Medical Director, or Medical Services Division, takes into consideration the recommendations of the Member's Provider and clinical information when making a decision about a Member's Benefit eligibility. When appropriate to review a proposed service, Anthem's Medical Director, or Medical Services Division, considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

SECTION 4: MAJOR MEDICAL BENEFITS - COVERED SERVICES

Please see Section 11 for Definitions of specially capitalized words.

This Section describes Covered Services for which HealthTrust provides Major Medical Benefits under the Plan. All Covered Services must be furnished by a Provider according to the terms and conditions of this Plan. Preventive Care services are listed in article II, A of this Section. All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, injury, or for maternity care. Otherwise, no Benefits are available.

Please note: Major Medical Benefits are Benefits that are in addition to Your Medicare Complementary Benefits. Major Medical Benefits do not duplicate coverage that is available under either Medicare Part A or Medicare Part B or under Your Medicare Complementary Benefits.

Please remember the Plan guidelines explained throughout the Certificate. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the limitations and exclusions, described in Section 5 and elsewhere in this Certificate and any amendments to this Certificate.

- To receive maximum Benefits for Covered Services, You must follow the terms of the Certificate, including using Participating Providers.

- Benefits for Covered Services are based on the Maximum Allowed Amount for such service.

- The Plan's payment for Covered Services will be limited by any applicable Coinsurance, or annual or lifetime payment limit indicated in this Certificate.

- The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.

- Anthem's determinations about Prior Approval requests, Medical Necessity, Experimental or Investigational Services and new technology are based on the terms of this Certificate, including but not limited to the definition of Medical Necessity. The definition of Medical Necessity is stated in Section 11. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefit Determinations regarding Medical Necessity. Please see Section 8 for more information.

Out-of-Pocket Costs. You are responsible for paying other costs, as follows:

- **Annual and Lifetime Coverage Limitations.** There are certain Annual and Lifetime Coverage Limitations that may apply under this Plan. You are responsible for the cost of services that exceed an Annual or Lifetime Coverage Limitation.

- **Major Medical Benefits Lifetime Maximum.** An overall Major Medical Benefits Lifetime Maximum of $1 million applies to Your coverage. Benefits paid for all Major Medical Covered Services count toward this maximum. You are responsible to pay any amount that exceeds the Major Medical Benefits Lifetime Maximum. Amounts that exceed the Maximum Allowed Amount do not count toward Your Major Medical Benefits Lifetime Maximum. If You previously were covered under an Anthem coverage or a HealthTrust sponsored health plan administered by Anthem, any benefits paid under such prior Anthem coverage or HealthTrust plan will be applied toward this Major Medical Benefits Lifetime Maximum.

- **Amounts That Exceed the Maximum Allowed Amount.** Benefits under this Plan are limited to the Maximum Allowed Amount. "Maximum Allowed Amount" means the dollar amount available for a specific Covered Service. The Maximum Allowed Amount is determined as stated in Section 11.

Amounts that exceed the Maximum Allowed Amount do not count toward meeting any cost sharing requirements or other out-of-pocket costs.

Participating Providers and BlueCard Providers agree to accept the Maximum Allowed Amount as payment in full. You are responsible for paying the difference between the Maximum Allowed Amount and the amount charged if You receive Covered Services from a Nonparticipating New Hampshire Provider or a NonBlueCard Provider outside New Hampshire.

- **Noncovered or Excluded Services.** You are responsible for paying the full cost of any service that is not described as a Covered Service in this Certificate. You are responsible for paying the full cost of any service that is excluded from coverage in this Certificate. This applies even if a Provider prescribes, orders or furnishes the service.

I. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. This includes maternity admissions. Coverage includes the following:

A. Care in a Short Term General Hospital. Semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Short Term General Hospital while You are a bed patient are covered. Custodial Care is not covered. Please see Section 5, II, K for a definition of Custodial Care.

Statement of Rights Under The Newborns' and Mothers' Health Protection Act. Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, discharges the mother or her newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care Provider obtain authorization from the plan or issuer for prescribing a length of stay up to 48 hours (or 96 hours).

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility. Semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while You are a bed patient are covered. When counting the number of Inpatient days, the day of admission is counted, but the day of discharge is not. Custodial Care is not covered. Please see Section 5, II, K for a definition of Custodial Care. Covered Services should be received from a Participating Provider.

C. Inpatient Physician and Professional Services. Physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests are covered. Benefits for Inpatient medical care are limited to daily care furnished by the attending physician, unless another physician's services are Medically Necessary, as determined by Your attending physician and Anthem.

Please see article V of this Section for information about Behavioral Health Care. Also, please see Section 5, I for important limitations and exclusions that may apply to Inpatient services.

II. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care. In general, the term "Preventive Care" under this Certificate refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. For Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed in this article, but otherwise services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this Certificate.

For the purposes of this article, the following Preventive Care services are covered:

1. Immunizations for babies, children and adults (including travel and rabies immunizations)

2. Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening

3. Routine physical exams for babies, children and adults (including an annual gynecological exam)

4. Family planning visits, such as medical exams related to family planning and genetic counseling. Outpatient or office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting or contraception injections.

Prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are not covered under this Certificate. No Benefits are available for services related to the use of nonprescription contraceptives. Examples of noncovered services are: contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges.

Fertility hormones and fertility drugs are not covered under this Certificate. Benefits for Infertility services are limited as explained in Section 5, I, E.

5. Nutrition Counseling, including but not limited to nutrition counseling for treatment of eating disorders, by a nutrition counselor practicing independently or as part of a physician practice or Outpatient hospital clinic. Other nutrition counseling Benefits are available when furnished by a Home Health Agency. Please see article IV, "Home Care" for more information. Benefits are limited to three visits per Member, per calendar year.

Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 6 below). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see Section 5, I, I, 4 "Surgery forconditions caused by obesity."

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

6. Diabetes Management Program. Covered Services must be ordered by a physician and furnished by a Diabetes Education Provider. Covered Services include:

- Individual counseling visits
- Group education programs and fees required to enroll in an approved group education program, and
- External insulin pump education for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see IV, E "Durable Medical Equipment, Medical Supplies, and Prosthetics" of this Section for information about coverage for external insulin pumps.

In addition to the limitations and exclusions listed in Section 5, the following limitations apply specifically to diabetes management services:

- No Benefits are available for service furnished by a Provider who is not a Diabetes Education Provider.
- Insulin, diabetic medications, glucose monitors, external insulin pumps and diabetic supplies are not covered under this article. Please see article IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about diabetic supplies.

Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see 5 above). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see Section 5, I, I, 4 "Surgery for conditions caused by obesity."

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Please note:

- **Routine vision exams** to determine the need for vision correction are not covered. Please see Section 5, I, J for coverage information for services for eye disease or injury.
- **Routine hearing exams** to determine the need for hearing correction are not covered. Please see Section 5, I, C for coverage information for services for ear disease or injury.

B. Medical/Surgical Care Furnished in a Physician's Office, Walk-In Center or Retail Health Clinic, or Furnished by an Independent Ambulatory Surgical Center, an Independent Infusion therapy Provider, an Independent Laboratory Provider or an Independent Radiology Provider.

In addition to preventive care commonly provided in a physician's office (see article A of this Section), the following services are covered:

1. Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments and radiation treatments).

2. Laboratory and x-ray tests (including allergy testing and ultrasound)

3. CT Scan, CTA, MRA, MRI, PET, SPECT, chemotherapy, infusion therapy

4. Medical supplies and drugs administered in an office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts for the prevention of disease, illness or injury or for therapeutic purposes. No Benefits are available for fertility hormones or fertility drugs under this Certificate.

Hormones, insulin and prescription drugs purchased at a Provider's office for use outside the office are not covered under this Certificate. Durable Medical Equipment, Medical Supplies and Prosthetics purchased for use outside a physician's office are covered under article IV, E of this Section.

5. Maternity Care. Total maternity care includes the Provider's fees for prenatal visits, delivery, Inpatient medical care and postpartum visits. Most often, Your Provider bills all of these fees together in one charge for delivery of a baby and includes all of these services combined. The Benefit is available according to the coverage in effect on the date of delivery.

Please note: If a Provider furnishes only prenatal care or the delivery, or postpartum care, Benefits are available according to the coverage in effect on the date You receive the care.

Benefits are available for routine maternity care furnished by a Network NHCM, provided that the Network NHCM is certified under New Hampshire law and acting within an NHCM's scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to, home deliveries. Out-of-Network NHCM services are covered only if the midwife is certified under New Hampshire law.

Benefits are available for Urgent and Emergency Care as described in Section 4 and all of the Medically Necessary Covered Services described in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy, termination of pregnancy or miscarriage. Ultrasounds during pregnancy are covered only when Medically Necessary.

Please see Section 5, I, E for important restrictions regarding infertility treatment.

Please note: Precertification is not required for maternity admissions. However, if You receive maternity care from a Nonparticipating Provider, please notify Anthem by calling the number on Your identification card.

C. Outpatient Facility Care in the Outpatient Department of a Hospital, or a Short Term General Hospital's Ambulatory Surgical Center, Hemodialysis Center or Birthing Center.

In addition to preventive care services commonly provided in an Outpatient facility (see article II, A of this Section), Benefits are available for Medically Necessary facility and professional services.

Coverage includes the following:

- Medical exams and consultations by a Provider
- Operating room for surgery or delivery of a baby
- Physician and professional services including surgery, anesthesia, delivery of a baby or management of therapy
- Hemodialysis, chemotherapy, radiation therapy, infusion therapy
- CT Scan, CTA, MRA, MRI, PET, SPECT
- Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation (a period of up to 24 hours during which Your condition is monitored to determine if Inpatient care is Medically Necessary)
- Laboratory and x-ray tests, including ultrasounds

D. Emergency Care. It may not always be possible or safe to delay treatment long enough to consult with Your Provider before You seek care. In a severe emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency Care provided in a licensed hospital emergency room is covered. Emergency Care means Covered Services You receive due to the sudden onset of a serious condition. A serious condition is a medical, or behavioral health condition that manifests itself by symptoms of such severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect that immediate medical attention is needed to prevent any of the following:

- Serious jeopardy to the person's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part or serious bodily disfigurement

Examples of conditions or symptoms that may require Emergency Care are: suspected heart attack or stroke; a broken bone; uncontrolled bleeding; unconsciousness (including as a result of drug overdose or alcohol poisoning) or You are at serious risk of harming Yourself or another person.

Emergency Care includes all of the Covered Services typically provided in a licensed hospital emergency room including, but not limited to, ancillary services to evaluate a person's condition and further medical examination and treatment as required to stabilize the person.

Please note: If You receive Nonparticipating Provider services in an emergency room You may be required to pay amounts that exceed the Maximum Allowed Amount.

E. Urgent Care. Urgent Care means Covered Services You receive due to a medical or mental health condition or symptomatic illness that if not treated within 48 hours presents a risk of serious harm. Examples of conditions that may require urgent care are: sprain, sore throat, rash, earache, minor wound, moderate fever or abdominal or muscle pain.

F. Ambulance Services. Benefits are available for Medically Necessary ambulance transport to a medical facility for Emergency Care. For example, coverage includes ambulance transport to a hospital from the scene of an accident or to a hospital from Your home due to symptoms of a heart attack.

In addition to the limitations and exclusions listed in Section 5, the following limitations apply to ambulance services:

- Nonemergency ambulance transport is not covered. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi except as stated in Section 5, I, G "Organ and Tissue Transplants."

- No Benefits are provided for transportation to or from medical appointments.

- Benefits are provided for air ambulance transport furnished by an air ambulance service to take You to a hospital only when it is Medically Necessary for You to be transported by air rather than ground ambulance. If Anthem determines that air ambulance transportation was not Medically Necessary, and that ground ambulance would have been Medically Necessary, the Plan will provide the Maximum Allowed Amount for a ground ambulance. In this case, You pay the difference between the Maximum Allowed Amount and the air ambulance charge.

III. Outpatient Physical Rehabilitation Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the Outpatient department of a Short Term General Hospital or Skilled Nursing Facility.

Physical therapy must be furnished by a licensed physical therapist. Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no Benefits are available.

Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions during the acute-care stage of an illness or injury. Otherwise, no Benefits are available. Covered Services for speech therapy are limited to:

- An evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary
- Individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist

No Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting.

No Benefits are available for educational reasons. No Benefits are available for sport, recreational or occupational reasons.

Except as stated in article, III, D, "Early Intervention Services," the following limitations and exclusions apply:

- Physical, occupational and speech therapy services must be furnished during the acute-care stage of an illness or injury. Therapy is covered for long-term conditions only when an acute medical condition occurs during the illness, such as following surgery.
- No Benefits are available for therapy furnished beyond the acute-care stage of an illness or injury. Therapy services must be restorative, with the expectation of concise, measurable gains and goals as judged by Your Provider and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of time. Noncovered services include, but are not limited to, ongoing or life-long exercise and education programs intended to maintain fitness, voice fitness or to reinforce lifestyle changes, including but not limited to lifestyle changes affecting the voice. Such ongoing services are not covered, even if ordered by Your Provider or supervised by skilled program personnel.
- No Benefits are available for Developmental Disabilities.

Please see Section 5, I, A, 4 "Dental Services" for Benefit information about physical therapy for treatment of TMJ disorders.

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs. The program must meet Anthem's standards for cardiac rehabilitation. Otherwise, no Benefits are available. Please call Anthem at the telephone number on Your identification card to determine program eligibility.

Covered Services include medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). No Benefits are available for home programs, on-going conditioning, or maintenance care.

C. Chiropractic Care. The following are Covered Services when furnished by a licensed chiropractor.

- Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment
- Medically Necessary diagnostic laboratory and x-ray tests

In addition to the limitations and exclusions stated in Section 5, the following limitations apply specifically to chiropractic care:

- Wellness care is not covered; and
- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a Participating Chiropractor or another physician.

You may choose to receive noncovered services. However, You are responsible for the full cost of any chiropractic care that is not covered, as stated above.

D. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care and psychological counseling provided by Eligible Behavioral Health Providers such as clinical social workers.

E. Cognitive Rehabilitation Therapy. Cognitive Rehabilitation Therapy services are covered for eligible Members only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.

IV. Home Care

Benefits are available for Medically Necessary Home Care. Covered Services are limited to the following:

A. Physician Services. Benefits are available for physician visits to Your home or place of residence to furnish medical/surgical care that is the same as or similar to services ordinarily provided in an office setting.

B. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by a Home Health Agency in Your home or other place of residence. Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for You to travel from Your home to another treatment site. Covered Services should be received from a Participating Provider.

Covered Services are limited to:

- Part-time or intermittent skilled nursing care by (or under the supervision of) a Registered Nurse
- Part-time or intermittent home health aide services that consist primarily of caring for You under the supervision of a Registered Nurse
- Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise, no Benefits are available. For example, if You are confined to bed rest, or Your activities of daily living are otherwise restricted by order of Your Provider, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, Anthem's case manager will consult with Your physician.
- Physical, occupational, or speech therapy
- Nonprescription medical supplies and drugs. Nonprescription medical supplies and drugs may include

surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included.

- Nutrition counseling provided as part of a covered home health plan. The nutrition counselor must be a registered dietitian employed by the covered Home Health Agency.

C. Hospice. Hospice care is home management of a terminal illness. Covered Services should be received from a Participating Provider. You are eligible for hospice care if Your doctor and the hospice medical director certify that You are terminally ill and likely have less than six months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness. Benefits are available for Hospice care, provided that the following conditions are met:

- Care must be approved in advance by the patient's Provider;
- The patient must have a terminal illness with a life expectancy of six months or less, as certified physician;
- The patient or his/her legal guardian, must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired;
- The patient or his/her legal guardian, the patient's Provider and medical team must support hospice care because it is in the patient's best interest; and
- A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient's care. The primary care giver does not need to live in the patient's home.

The hospice Provider and Anthem will establish an individual hospice plan that meets Your individual needs. Each portion of a hospice plan must be Medically Necessary. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

- Skilled nursing visits;
- Home health aide and homemaker services;
- Physical therapy for comfort measures;
- Social service visits;
- Durable medical equipment and medical supplies;
- Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions;
- Continuous care, which is additional respite care to support the family during the patient's final days of life;
- Short-term Inpatient hospital care when needed in periods of crisis or as respite care; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver, and individuals with significant personal ties, for one year after the Member's death.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in hospice. These services are Covered Services under other parts of the Plan.

D. Infusion Therapy. Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy Provider. Covered Services should be received from a Participating Provider. Covered Services include:

- Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy;
- Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients; and
- Associated supplies and portable, stationary or implantable infusion pumps.

E. Durable Medical Equipment, Medical Supplies, and Prosthetics. Benefits are available for durable medical equipment (DME), medical supplies, and prosthetics. Covered Services must be ordered by a physician and furnished by a licensed medical equipment, medical supplies or prosthetics Provider. Otherwise, no Benefits are available.

1. Durable Medical Equipment (DME). Benefits are available for covered DME. In order to be covered, the DME must meet all of the following criteria, otherwise no Benefits are available. The DME must be:

- Primarily and customarily used for a medical purpose;
- Useful only for the specific illness or injury that Your Provider has diagnosed or suspects;
- Non-disposable and specifically designed and intended to withstand repeated use; and
- Meant for use outside a medical facility.

Examples of covered DME include, but are not limited to, crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, special hospital type beds and home dialysis equipment. Enteral pumps and related equipment are covered for Members who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

Benefits are available for external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved in advance by Anthem. To determine eligibility, please ask Your physician to contact Anthem for prior approval *before* You purchase the pump. Anthem will require treatment and clinical information in writing from Your physician. Anthem will review the information and determine in writing whether the services are covered under this Certificate, based on the criteria stated in this Certificate and Anthem's guidelines for external infusion pumps. You may contact Anthem to request a copy of Anthem's internal guidelines or log in to Your secure account at *www.healthtrustnh.org.* Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate. Please see article II, A, 6 of this Section for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

Benefits are also available for certain types of orthotics (braces, boots, splints). No Benefits are available for hearing aids.

2. Medical Supplies. Benefits are available for medical supplies. In order to be covered, medical supplies must be small, disposable items designed and intended specifically for medical purposes and appropriate for treatment of the specific illness or injury that Your Provider has diagnosed. Otherwise, no Benefits are available.

Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of Your eye has been surgically removed or is congenitally absent.

Other covered medical supplies are:

- **Diabetic supplies**. Diabetic supplies are covered for Members who have diabetes. Examples of covered diabetic supplies include, but are not limited to, diabetic needles and syringes, glucose monitors, test strips and lancets. Coverage is provided under this article when supplies are purchased from a licensed DME Provider.

- **Enteral formula and modified low protein food products.** Benefits are available for enteral formulas required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. Benefits are limited to a total of $1,800 per Member, per calendar year for modified low protein food products. To be eligible for Benefits, Your physician must issue a written order stating that the enteral formula and/or food product is:

- Needed to sustain life;
- Medically Necessary; and
- The least restrictive and most cost-effective means for meeting Your medical needs.

Otherwise, no Benefits are available.

3. **Prosthetics.** Benefits are available for prosthetics that replace an absent body part or the function of a permanently impaired body part. Prosthetic limbs are covered prosthetics. Prosthetic limbs are artificial devices that replace, in part or in whole, an arm or leg. Post-mastectomy breast prostheses and scalp hair prosthesis are other examples of covered prosthetic devices.

Coverage for external breast prostheses is limited to two prostheses per breast, per calendar year. The Maximum Allowed Amount for breast prosthesis includes the cost of fitting for the prosthesis.

Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post-mastectomy bras is limited to three bras per Member, per calendar year.

Scalp Hair Prostheses (Wigs). A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for You. Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury. For Members who have hair loss as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, Benefits are limited to a total of $350 per Member per calendar year.

To be eligible for Benefits, Your Provider must state in writing that the prosthesis is Medically Necessary. You must submit Your Provider's statement with Your claim.

Except as described above, no Benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no Benefits are available for temporary hair loss. No Benefits are available for male pattern baldness.

4. **Limitations.** In addition to the limitations and exclusions listed in Section 5, the following limitations apply specifically to this article E:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount for the least expensive service that meets Your medical needs. If Your service is more costly than is Medically Necessary, You will be responsible for paying the difference between the Maximum Allowed Amount for the least expensive service and the charge for the more expensive service.

- If You rent or purchase equipment and Benefits are paid equal to the Maximum Allowed Amount, no further Benefits will be provided for rental or purchase of the equipment.

- Anthem is given the right to determine if equipment should be rented instead of purchased. For example, if Your physician prescribes a hospital bed for short-term home use, the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, Benefits are limited to what would be paid for rental, even if You purchase the equipment. You will be responsible for paying the difference between the Maximum Allowed Amount for rental and the charge for purchase.
- Burn garments (or burn anti-pressure garments) are covered only when prescribed by Your physician for treatment of third degree burns, deep second degree burns or for areas of the skin that have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.

- Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered, provided that the stockings are prescribed by Your physician and are Medically Necessary, as defined in Section 11. Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The Maximum Allowed Amount for covered gradient pressure aids includes the Benefit for fitting of the garment. No additional Benefits are available for fitting.

- Neither rental nor purchase of manual breast pumps is covered.

- Electric breast pumps are not covered. Exception: Rental of an electric breast pump may be covered for up to two months, provided that pump is Medically Necessary, as stated in Section 11. Purchase of an electric breast pump is not covered.

- Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant's head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a reconstructive service found in Section 5, I, I "Surgery." To be eligible for Benefits, an infant Member must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no Benefits are available for cranial helmets or any other device intended to change the shape of a child's head.

- Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a physician's supervision with regularly scheduled exams. The therapy is covered only for treatment of the following skin disorders: severe atopic dermatitis and psoriasis, mild to moderate atopic dermatitis or psoriasis (when standard treatment has failed, as documented by medical records), lichen planus, mycosis fungoides, pityriasis lichenoides, pruritus of hepatic disease and pruritus of renal failure. UVB home therapy is not covered for any other skin disorder. Ultraviolet light A home therapy (UVA) is not covered. Please see Section 5, I, M, "Ultraviolet Light Therapy and Laser Therapy for Skin Disorders," for information about out-of-home ultraviolet light therapy.

5. **Exclusions.** In addition to the limitations and exclusions listed in Section 5, the following services and supplies are not covered. These exclusions apply even if the services or supplies are provided, ordered or prescribed by a Provider and even if the services or supplies meet the definition of Medical Necessity found in Section 11 of this Certificate.

No Benefits are available for:

- Foot orthotics (orthopedic shoes or footwear or support items), unless used for systemic illness affecting the lower limbs, such as severe diabetes.
- Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds.
- Sports glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in above in this article.
- Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, or items for personal hygiene.
- Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans.
- Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems).
- Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device.
- Safety equipment, including, but not limited to, hats, belts, harnesses, safety glasses or restraints.
- Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system.
- Self-monitoring devices (except as stated in 2 “Medical Supplies” above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for websites or software, or any other media instruction or for any other educational or instructional material, technology or equipment.
- Dentures, orthodontics, dental prosthesis and appliances.
- Convenience and personal care services and supplies. Please see Section 5, II, J for a definition of “Convenience Services.”

Except as specified in this article and in any amendment to this Certificate, no Benefits are available for the cost of Durable Medical Equipment, Medical Supplies, or Prosthetics.

V. Behavioral Health Care (Mental Health and Substance Use Care)

A. Behavioral Health Care. Benefits are available for Medically Necessary Behavioral Health Care. Behavioral Health Care means the Covered Services described in this article for diagnosis and treatment of Mental Disorders and Substance Use Conditions as defined below:

- **A Mental Disorder** is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. The term "Mental Disorder" does not include chemical dependency such as alcoholism. A Mental Disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

  Mental Disorders include:

  - Schizophrenia and other psychotic disorders such as, but not limited to, paranoia
  - Schizoaffective disorder
  - Major depressive disorder
  - Bipolar disorder
  - Obsessive compulsive disorder
  - Pediatric autoimmune neuropsychiatric disorder
  - Panic disorder
  - Anorexia nervosa
  - Bulimia nervosa
  - Chronic post-traumatic stress disorder

- **A Substance Use Disorder** is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and/or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost. Nicotine addiction is not a Substance Use Disorder under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Use Condition, Anthem will refer to the most current edition of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association and may also refer to the International Classification of Diseases (ICD) Manual.

B. Covered Services. Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C below**.**

Benefits are available for the following Covered Services:

1. **Outpatient/Office Visits.** Covered Services include diagnosis and evaluation, therapy and treatment, medication checks, detoxification, rehabilitation, and psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates.

   Outpatient services may be provided in an office, or in an outpatient department of a hospital or other covered Outpatient facility.

2. **Partial Hospitalization and Intensive Outpatient Treatment Programs.** Benefits are available for Partial Hospitalization and Intensive Outpatient Treatment Programs (sometimes called "day/evening" programs) for treatment of Mental Disorders and Substance Use Disorders.

   Charges in excess of Benefit Maximums are Your responsibility.

3. **Inpatient Services.** Covered Services include Medically Necessary services in a hospital or other facility typically provided as part of an Inpatient admission for treatment of Mental Disorders or Substance Use Disorders. Benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and rehabilitation. For treatment of Substance Use Disorders, Benefits include clinical stabilization services and short-term Inpatient withdrawal management.

   Emergency Room Boarding in New Hampshire Hospitals. Following the completion of an involuntary admission certificate for a Member, the Plan will cover board and care for the Member waiting in an Emergency Department of an acute care hospital located in the State of New Hampshire for each day the Member is waiting for admission for psychiatric treatment to the New Hampshire State Hospital, a community-based designated receiving facility, or a voluntary admission, for up to 21 consecutive days or more until discharged.

4. **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

   - Observation and assessment by a physician weekly or more often; and
   - Rehabilitation and therapy.

C. Eligible Behavioral Health Providers. As approved by Anthem, Eligible Behavioral Health Providers from whom You can receive Covered Services for Behavioral Health Care include, without limitation, the following:

- Psychiatrist
- Licensed psychologist
- Neuropsychologist
- Licensed clinical social worker
- Psychiatric Advanced Practice Registered Nurse
- Licensed marriage and family therapist
- Licensed clinical mental health counselor
- Licensed alcohol and drug abuse counselor
- Community Mental Health Center
- Licensed pastoral psychotherapist
- Short Term General Hospital
- Residential Treatment Center
- Private or Public Hospital
- Partial Hospitalization or Intensive Outpatient Program (day treatment program)
- Substance Use Disorder Treatment Provider
- Any agency licensed by the state to give these services when we have to cover them by law.

VI. Medicare Part B Excess Charge

Some Providers do not accept assignment of benefits from Medicare for Part B services. Providers who do not accept assignment may charge an amount in excess of the amount Medicare pays. Medicare will pay You an amount for Medicare Eligible Part B Expenses, less any applicable Part B Coinsurance or Part B Deductible. Your Medicare Complementary Benefits cover the Part B Coinsurance and Part B Deductible. The Major Medical Benefits under this Certificate provide Benefits for the difference between the actual Medicare Part B allowance and the additional amount the Provider is permitted to charge as established by Medicare or state law. Typically, the Medicare Part B excess charge is 15% over the amount allowed by Medicare for Medicare Eligible Part B Expenses.

SECTION 5: MAJOR MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS

Please see Section 11 for Definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the "Major Medical Benefits - Covered Services" provided in Section 4. In addition to other limitations, conditions or exclusions set forth elsewhere in this Certificate, Benefits for expenses related to the services, supplies, conditions or situations described in this article are limited as indicated below. Limitations apply to these items and services even if You receive them from a Participating Provider.

Please remember, this Plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of limitations is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is given the right to determine if services or supplies are Covered Services.

Determinations about Medical Necessity, Experimental or Investigational Services and new technology are based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity found in Section 11. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefit Determinations regarding Medical Necessity. Please see Section 8 for more information about the appeal process.

A. Dental Services. The following dental services are covered:

1. Treatment of Accidental Injury to Sound Natural Teeth. Benefits are available for Medically Necessary Dental Services resulting from accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered consistent with terms and conditions of this Certificate.

No Benefits are available for diagnosis or treatment if You damage Your teeth, supporting structure or appliances as a result of biting or chewing. No Benefits are available to repair, restore or replace items such as fillings, crowns, caps or appliances.

2. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease.

3. Medically Necessary hospital charges (Inpatient or Outpatient), surgical day care facility charges and administration of general anesthesia by a licensed anesthesiologist or anesthetist.

4. Oral Surgery and Treatment of Temporomandibular Joint (TMJ) Disorders. Covered Services include:

a. Oral Surgery. Benefits are available for the surgical removal of bone impacted teeth and gingivectomy. Coverage is limited to:

- The surgeon's fee for the surgical procedure (no Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services),
- Intravenous sedation furnished by the operating dentist or oral surgeon, and
- Anesthesia furnished by an anesthesiologist who is not the operating dentist or oral surgeon.

- Gingivectomy is limited to excision of the soft tissue wall of the "pocket," up to four quadrants per lifetime.

No Benefits are available for anesthesia services by the surgeon, surgical exposure of impacted teeth to aid eruption, osseous and flap procedures in conjunction with gingivectomy or any other services for periodontal disease (such as scaling and root planing, prophylaxis and periodontal evaluations).

b. Orthognathic Surgery. Benefits are available for Medically Necessary orthognathic surgery to correct jaw and craniofacial deformities causing significant functional impairment.

c. Treatment of Temporomandibular Joint (TMJ) disorders. Coverage is limited to:

- Surgical correction or repair of the temporomandibular joint (TMJ) is covered, provided that the Member has completed at least five months of unsuccessful non-surgical treatment, as medically documented. Coverage is limited to surgical procedures that are Medically Necessary to correct or repair a disorder of the temporomandibular joint, caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.

- Medical exams and medical treatment for the initial evaluation, follow-up treatment for adjustment of an orthopedic repositioning splint and trigger point injection treatment are covered.

- Diagnostic x-rays of the TMJ joint and other facial bones are covered.

- Physical therapy. The therapist must bill services separately from the dentist or oral surgeon who directs Your TMJ treatment.

Orthopedic repositioning splints. This is limited to one splint per Member, per lifetime up to a maximum Benefit of $350.

- Diagnostic arthroscopy for TMJ disorders is not covered.

Except as stated above, no Benefits are available for treatment of cavities, tooth extractions, care of the gums, teeth, or bones supporting the teeth, treatment of a periodontal disorder, disease or abscess, services, supplies or procedures to change the height or position of teeth or otherwise restore occlusion (such as bridges, crowns or orthodontia, including braces), false teeth, or any other dental service.

No Benefits are available for x-rays of the teeth, biofeedback training, occlusal adjustments and dental procedures such as tooth build-up or occlusal appliances (such as night guards, trismus appliances, bruxism splints or occlusal guards). Orthodontic care and orthodontic appliances are not covered under any portion of this Certificate.

No Benefits are available for noncovered dental procedures, even when Your Provider and Anthem authorize hospitalization and anesthesia for the procedure. No Benefits are available if You damage Your teeth or appliances as a result of biting or chewing.

B. Experimental or Investigational Services and Clinical Trials. Anthem is given the right to determine if services or supplies are Experimental or Investigational. The Plan will not pay for services or supplies which Anthem has determined to be Experimental or Investigational in nature. No Benefits are available for services related to, resulting from, arising or provided in connection with Experimental or Investigational services, except for routine patient care costs related to certain drugs and devices that are the subject of clinical trials, as stated in 2 below.

1. **Experimental or Investigational** means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be Experimental or Investigational.

   a. Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

      - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted;
      - Has been determined by the FDA to be contraindicated for the specific use;
      - Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
      - Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
      - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

   b. Any Service not deemed Experimental or Investigational based on the criteria in (a) may still be deemed to be Experimental or Investigational by Anthem if:

      - The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
      - The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
      - The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
      - The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

   c. The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under (a) and (b) above may include one or more items from the following list which is not all inclusive:

      - Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof;

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent document(s) used by the treating physicians, other medical professionals, or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

Anthem is given the authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational. Anthem's medical policy assists in Anthem's reviews. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

2. Clinical Trials. Benefits are available for Medically Necessary services, such as routine patient care costs, provided to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. Benefits are subject to the cost sharing amounts on Your Cost Sharing Schedule. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term "life-threatening condition" means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

a. The National Institutes of Health
b. The Centers for Disease Control and Prevention
c. The Agency for Health Care Research and Quality
d. The Centers for Medicare & Medicaid Services
e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
g. The Department of Veterans Affairs, The Department of Defense, or The Department of Energy, provided that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. Studies or investigations done as part of an Investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials which are exempt from the Investigational new drug application.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to Anthem's clinical coverage guidelines, related policies and procedures. Your Plan is not required to provide Benefits for the following services. The Plan reserves the right to exclude any of the following:

- The Investigational item, device, or service;
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

C. Hearing Services. Benefits are available for diagnosis and treatment of ear disease or injury. Covered Services (Inpatient and Outpatient care) are described in Section 4. Your Provider must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by an audiologist, provided that Your Provider finds or suspects injury to the ear or a diseased condition of the ear.

No Benefits are available for routine hearing services to determine the need for hearing correction. No Benefits are available for hearing aids.

D. Growth Hormone Treatment. No Benefits are available for any growth hormone treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones) solely to increase or decrease height or alter the rate of growth, except:

- Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone, or
- To treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant

Human growth hormones must be authorized *in advance* by the child's Provider and must be approved for Medical Necessity by Anthem. Please call the number on Your identification card for approval.

E. Infertility Diagnostic Services. Benefits are available for the Infertility Services listed in this article. To be eligible for Benefits, Covered Services must be Medically Necessary. Coverage is not available to partners who are not Members.

For the purposes of determining Benefit availability, "Infertility," which may occur in either a male or female, is defined as the inability to become pregnant or to carry a pregnancy to live birth, or the inability to cause pregnancy and live birth, in accordance with guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology. Male infertility may include but is not limited to blockage of the seminal tract, a congenital absence or congenital obstruction of the vas deferens, or low sperm motility or quantity. Please note that menopause in a woman is considered a natural condition and is not considered "Infertility" as defined in this Certificate.

Covered Services are limited to the following diagnostic services:

- Medical exams,
- Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests,
- Surgical procedures to determine the cause of infertility and surgical procedures to correct medical conditions contributing to infertility
- Ultrasound and other imaging exams, such as hysterosalpingography, to determine the cause of infertility or to establish tubal patency.

Covered Services to determine the cause of medically documented infertility may be provided to male or female Members. Coverage is not available to partners who are not Members.

No Benefits are available for the treatment of infertility. No Benefits are available for the following services or any care related to these services:

- Any infertility procedure performed during an operation not related to an infertility diagnosis
- Male or female fertility drugs and hormones administered in an Outpatient setting, and any service to prescribe or monitor the use of fertility drugs or hormones
- Sonograms (ultrasounds), laboratory services, radiological services or any other service related to a noncovered procedure
- Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or cryopreservation, microfertilization (egg drilling or tweaking)
- Sperm penetration assays, electroejaculation procedures
- Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID)
- Assisted reproduction technology (ART), such as intravaginal culture, microvolume straw technique, in-vitro fertilization and embryo transfer (IVF-ET), natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), peritoneal ovum and sperm transfer (POST), zygote intrafallopian transfer (ZIFT), cryopreservation of embryos or cryopreserved embryo transfer (CET), direct intraperitoneal insemination (DIPI), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD)
- Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching
- Microsurgical epididymal sperm aspiration (MESA)
- Genetic engineering, any selective fetal reduction

- Any service related to achieving pregnancy through surrogacy or gestational carriers
- Diagnosis and treatment following voluntary sterilization
- Supplies (such as thermometers and kits to predict ovulation)
- Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.

The above exclusions apply whether or not a Member has a medically documented diagnosis of infertility. Please see article II of this Section for other exclusions that may apply.

If You have questions about Benefit eligibility for a proposed Infertility Service, You are encouraged to contact Anthem before You receive the service. Your Provider should submit a written description of the proposed service to: Anthem Blue Cross and Blue Shield, P.O. Box 660, North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested service is covered or excluded under this Certificate. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefit Determinations regarding coverage for Infertility Services.

F. Private Room. If You occupy a private room, You will have to pay the difference between the hospital's charges for a private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for You to occupy a private room. Your Provider must provide Anthem with a written statement in advance regarding the Medical Necessity of Your use of a private room, and Anthem must agree in advance that private room accommodations are Medically Necessary.

G. Human Organ and Tissue Transplant Services. Benefits are available for Medically Necessary human solid organ and tissue transplants according to the terms of this article. Covered Services (Inpatient and Outpatient) are stated in Section 4. Transplants must be ordered by Your Provider and approved in advance by Anthem. You and the organ donor must receive services from a Participating Provider or other Provider, as determined by Anthem. Otherwise, no Benefits are available.

The organ recipient must be a Member. When the organ donor is a Member, and the recipient is not a Member, no Benefits are available for services received by the donor or by the recipient. **Exception:** Human leukocyte antigen laboratory tests (histocompatibility locus antigen testing) to screen for the purposes of identifying a Member as a potential bone marrow transplant donor is covered, even if there is no specified recipient at the time of screening and/or an identified recipient is not a Member. Benefits are limited to the Maximum Allowed Amount as allowed by law. New Hampshire law prohibits Providers from billing Members for the difference between the Maximum Allowed Amount and the Provider's charge.

The screening for potential donors is covered only if, at the time of the testing:

- The Member meets the criteria for testing as established by Match Registry (the National Marrow Donor Program), and
- The screening is furnished by a Network Provider acting within the scope of the Provider's license.

Otherwise, no Benefits are available for human leukocyte antigen testing to identify potential bone marrow transplant donors when the recipient is not a Member.

Benefits are available only if You meet all of the criteria for transplant eligibility as determined by Anthem and by the Provider. The transplant must be generally considered the treatment of choice by Anthem and by the Provider. Otherwise, no Benefits are available. Transplants are not covered for patients with certain systemic diseases, contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

Covered Services. The following transplants are covered if all of the conditions stated in this article are met:

- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas

- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome

- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Autologous bone marrow transplants are covered for breast cancer consistent with New Hampshire law.

- Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis.

- Small bowel transplants for Members with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Due to advances in transplant procedures and constantly changing medical technology, Anthem is given the right to periodically review and update the list of transplant procedures that are Covered Services. For the most up to date list of covered transplant procedures, please contact Anthem Member Services at the number on Your identification card.

Benefits are available for the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of a human solid organ or other human tissue used in a covered transplant procedure. Benefits are available only to the extent that the costs are not covered by other insurance.

Expenses that are directly related to the surgical, storage and transportation costs for the organ that is used in a covered transplant are covered up to a $10,000 maximum for each completed covered transplant.

Transportation costs for travel to and from the site for the transplant surgery for the patient and one other individual and lodging and meal costs for the individual other than the patient are covered expenses. If the transplant recipient is a minor, transportation, lodging and meal costs are extended to two other individuals. Total transportation, and reasonable and necessary lodging and meal costs, not to exceed $150 per day, are not to exceed a maximum of $10,000 for the patient and all accompanying individuals for each completed covered transplant.

No Benefits are available for any transplant procedure that is not a Covered Service. Except as stated in article I, B, 2 of this Section, Experimental or Investigational transplant procedures and any related care (including care for complications of a non-covered procedure) are not covered. No Benefits are available for procedures that are not Medically Necessary. No Benefits are available for any service or supply related to surgical procedures for artificial

or nonhuman organs or tissues. No Benefits are available for transplants using artificial parts or nonhuman donors. Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes, but is not limited to, services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

H. Required Exams or Services. Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by a Provider; and
- All of the terms and conditions of this Certificate are met.

No Benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat an illness or injury that Your Provider finds or reasonably suspects. No Benefits are available for examinations or services that are required to obtain or maintain employment, insurance or professional or other licenses. No Benefits are available for examinations for participation in athletic or recreational activities, or for attending a school, camp, or other program, unless furnished during a covered medical exam, as described in Section 4.

I. Surgery. Benefits are available for surgical services on an Inpatient or Outpatient basis, including office surgeries.

Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary; and
- Medically Necessary pre-operative and post-operative care.

Under the terms of this article, surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs or trigger point injections for treatment of TMJ disorders. Surgery does not include any service excluded from coverage under the terms of this Certificate.

Limitations. In addition to the limitations and exclusions stated elsewhere in this Certificate, the following limitations apply to surgery:

1. Reconstructive Surgery. Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction to both affected breasts or one affected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the physician.

Otherwise, Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. Reconstructive surgery or services must be:

- Made necessary by accidental injury;

- Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;

- Necessary to restore or improve a bodily function; or

- Necessary to correct birth defects for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate.

Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of this Certificate.

Benefits are available based on the criteria stated in this Certificate. Please see article IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about coverage for helmets or adjustable bands used to change the shape of an infant's head.

2. **Cosmetic Services**. Cosmetic Services are not covered under any portion of this Certificate. Please see article II, K below for a definition of Cosmetic Services.

3. **Dental Services.** Dental Services are covered only as stated above in article A, "Dental Services." Except as stated above in A, no Benefits are available for Dental Services, including dental surgery, under any portion of this Certificate.

4. **Surgery for Conditions Caused by Obesity**. Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. The definition of Medical Necessity is found in Section 11. When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of this Certificate, even if the surgery, service or program is ordered by Your physician or performed or ordered by another Provider. This exclusion applies even if the surgery, service or program meets the definition of Medical Necessity. Except as stated in this article, no Benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

Please see Section 4, II, A, 5 and 6 "Nutrition Counseling" and "Diabetes Management Programs" for information about Benefits for non-surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

5. **Postoperative Medical Care.** Postoperative medical care is the medical care related to and provided after the surgery. The Maximum Allowed Amount for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowed Amount are available for surgery-related postoperative medical care.

6. **Human Organ and Tissue Transplant Surgery.** Please see G "Human Organ and Tissue Transplant Services" (above in this article) for important information about coverage and limitations for organ/tissue transplant surgery.

7. **Intravenous (IV) Sedation and Local Anesthesia.** The Maximum Allowed Amount for surgery includes the Benefit payment for IV sedation and/or local anesthesia. No Benefits beyond the surgical Maximum Allowed Amount are available for IV sedation and/or local anesthesia.

8. **Surgery Related to Noncovered Services**. No Benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. This exclusion applies even if the service is furnished or ordered by Your physician or other Provider and meets the definition of Medical Necessity.

If Your proposed surgical services may be considered reconstructive, cosmetic, dental, weight loss/weight management surgery or if Your surgical services may be considered noncovered under other portions of this Certificate, You should contact Anthem *before* You receive the services. Please ask Your physician to submit a written description of the service to:

Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660.

Anthem will review the information and determine in writing whether the requested services are covered or excluded under this Certificate. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

J. **Vision Services.** Benefits are available for the diagnosis and treatment of eye disease or injury. Covered Services (Inpatient and Outpatient care) are described in Section 4.

Eyewear (frames, lenses and contact lenses) is covered for medical conditions only as stated in Section 4, IV, E, 2

No Benefits are available for:

- Routine vision care to determine the need for vision correction or for the prescription and fitting of corrective, including contact, lenses
- Services, supplies or charges for eye surgery to correct errors of refraction, such as near-sightedness, including, without limitation, radial keratotomy and PRK Laser (photo refractive keratectomy) or excimer laser refractive keratectomy
- Eyewear (frames, lenses and contact lenses) for routine vision correction
- Vision therapy including, without limitation, treatment such as vision training, orthoptics, eye training, or eye exercises

K. **Private Duty Nurses.** Benefits for Medically Necessary services of an actively practicing private-duty nurse for the duration of an acute illness are limited to:

- Services in a hospital of a registered nurse (R.N) or a licensed practical nurse (L.P.N.).
- Services out of a hospital, including in Your home, of a registered nurse (R.N.). The services of a licensed practical nurse (L.P.N.) will be covered if the services are certified by Your Provider and the services of a registered nurse (R.N.) are not available.
- The nurse may not be a relative or a member of Your family.

L. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light therapy and laser therapy as follows:

- Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.

- Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.

- Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:

    - The inflammation is limited to less than or equal to 10% of the Member's body surface area, and

    - The Member has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy, and the conservative therapy was not successful as documented in medical records.

  Please see Section 4, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for Medically Necessary equipment and supplies for home ultraviolet light therapy for skin disorders. Except as stated in Section 4 and in this article, no Benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders.

  This limitation applies even if the therapy is furnished, prescribed, or supervised by a Provider and even if the therapy meets the definition of Medical Necessity.

II. Exclusions

Major Medical Benefits are not available for the following items or services, unless required by federal law. In addition to other limitations, conditions and exclusions set forth elsewhere in this Certificate, no Benefits are available for expenses related to the services, supplies, conditions or situations described in this article. These items and services are not covered even if provided by a Participating Provider.

Please remember, this Plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is given the right to determine if services or supplies are Covered Services.

A. Alternative or Complementary Medicine. No Benefits are available for services or supplies for alternative or complementary medicine, even if the service or supply is recommended by Your physician and is beneficial to You. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven, established or medically documented or otherwise fails to meet the definition of Medical Necessity as stated in Section 11. Services or supplies for alternative or complementary medicine include, but are not limited to:

- Acupuncture
- Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body
- Holistic medicine
- Homeopathic medicine
- Hypnosis
- Aroma therapy

- Massage and massage therapy
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Thermography
- Orthomolecular therapy
- Contact reflex analysis
- Bioenergial synchronization technique (BEST)
- Iridology-study of the iris
- Auditory integration therapy (AIT)
- Colonic irrigation
- Magnetic innervation therapy
- Electromagnetic therapy
- Neurofeedback / Biofeedback.

B. Amounts That Exceed the Maximum Allowed Amount. Benefits for Covered Services are limited to the Maximum Allowed Amount. As stated in this Certificate, You may be responsible for any amount that exceeds the Maximum Allowed Amount. See Sections 6, I and 11 for the definition of Maximum Allowed Amount.

C. Artificial Insemination. In general terms, "artificial insemination" refers to insemination by any means other than natural sexual intercourse. No Benefits are available for artificial insemination, any assistive reproduction technology or any related service. Please see article I, E of this Section for detailed information.

D. Blood and Blood Products. No Benefits are available for costs related to the donation, drawing or storage of designated blood. Designated blood is blood that is donated and then designated for a specific person's use at a later date. No Benefits are available for blood, blood donors, blood products or packed red blood cells when participation in a volunteer blood program is available.

E. Care Furnished by a Family Member. No Benefits are available for care furnished by an individual who normally resides in Your household or is a member of Your immediate family. Your immediate family is defined to include parents, siblings, spouses, children, grandparents, in-laws, and You.

F. Care Received When You are not Covered Under this Certificate. No Benefits are available for any service that You receive *before* the effective date of Your coverage or after Your coverage ends, except as specifically stated in this Certificate.

If an Inpatient admission began *before* the effective date of Your coverage under this Certificate, Benefits will be provided under this Certificate for Inpatient days occurring on or after the effective date of Your coverage under this Certificate, unless this coverage replaces that of another carrier and the terms of the prior carrier's policy provides coverage for the entire admission (admission date to discharge date).

Except as stated in Section 10, IV, "Continuation of Group Coverage," Benefits are not available for Inpatient days or any other services that occur after the termination date of coverage under this Certificate.

G. Care or Complications Related to Noncovered Services. No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in article I, A of this Section.

H. Chelating Agents. No Benefits are available for any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

I. Convenience and Personal Care. No Benefits are available for the cost of any item or service that is primarily for convenience or personal care, even if provided while You are ill or injured, under the care of a Provider, and even if the services are furnished, ordered or prescribed by a Provider.

Items and services in this category include, but are not limited to:

- Items for personal comfort, convenience, protection, or cleanliness (such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs);
- First aid supplies and other items kept in the home for general use (such as bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
- Home workout or therapy equipment, including treadmills and home gyms;
- Pools, whirlpools, spas, or hydrotherapy equipment;
- Hypo-allergenic pillows, mattresses, or waterbeds;
- Residential, auto, or place of business structural changes (such as ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails); and
- Consumer wearable/personal mobile devices (such as a smartphone, smartwatch, or other personal tracking devices), including any software or applications.

J. Cosmetic Services. Except as stated in article I of this Section, no Benefits are available for Cosmetic Services or for any care, procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how You look or are given for social reasons. Examples of Cosmetic Services include surgery or treatments to change the texture or appearance of Your skin, and surgery or treatments to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts).

K. Custodial Care. No Benefits are available for services, supplies or charges for Custodial Care. This includes any type of care, including room and board, that (i) does not require the skills of professional or technical workers; (ii) is not given to You or supervised by such workers or does not meet the rules for post-hospital Skilled Nursing Facility care; and (iii) is given when You have already reached the greatest level of physical or mental health and are not likely to improve further. Care can be Custodial Care even if it is recommended by a professional or performed in a facility, such as a hospital or Skilled Nursing Facility, or at home. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet;
- Changing dressings of non-infected wounds after surgery or chronic conditions;
- Preparing meals and/or special diets;
- Feeding by utensil, tube, or gastrostomy;
- Common skin and nail care;
- Supervising medicine that You can take Yourself;
- Catheter care, general colostomy or ileostomy care;
- Routine services which Anthem decides can be safely done by You or a non-medical person without the help of trained medical and paramedical workers;
- Residential care and adult day care;
- Protective and supportive care, including education; and
- Rest and convalescent care.

L. Disease or Injury Sustained as a Result of War, or Participation in a Riot, Insurrection or Criminal Activity. No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot, or other act of insurrection. Unless otherwise required by law or regulation, Benefits are not available for illness or injury when the cause of the illness or injury was a Member's commission of any criminal activity.

M. Educational Services and Developmental Disability Services. No Benefits are available for services, supplies or room and board for teaching, vocational, or self-training purposes, except as specifically stated in this Certificate. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

Except as stated in Section 4, III, D "Early Intervention Services" and Section 4, V" Behavioral Health Care," no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

N. Food and Food Supplements. No Benefits are available for foods, food supplements or for vitamins except as provided under Section 4, IV, E. "Durable Medical Equipment, Medical Supplies and Prosthetics" Please refer to that Section for information about Benefits.

O. Foot Care. No Benefits are available for routine foot care unless Medically Necessary. This exclusion applies to: cutting or removing corns and calluses; trimming nails; or cleaning and preventive foot care, including but not limited to (i) cleaning and soaking the feet, (ii) applying skin creams to care for skin tone, and (iii) other services that are provided when there is not an illness, injury or symptoms involving the foot.

P. Foot Orthotics. No Benefits are available for foot orthotics, orthopedic shoes or footwear, or support items, unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

Q. Foot Surgery. No Benefits are available for surgical treatment of: flat feet; subluxation of the foot; weak, strained, or unstable feet; tarsalgia; metatarsalgia; or hyperkeratoses.

R. Free Care. No Benefits are provided for any care if the care is furnished to You without charge or would normally be furnished to You without charge. This exclusion will also apply if the care would have been furnished to You without charge if You were not covered under this Certificate or under any other health benefit plan or other insurance.

S. Government Programs. No Benefits are available for Covered Services to the extent that benefits for such services are paid or payable (or could reasonably be expected to be payable if a claim were made) under any of the following:

- Medicare or any other federal, state or local government program for which the government is the primary payer, including CHAMPUS/TRICARE. Benefits are available under this Certificate even though You may be eligible for Medicaid; or

- Any federal, state, county, municipal, or other government agency, including Medicare and the Veteran's Administration, for service-connected disabilities.

T. Health Club Memberships. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

U. Home Test Kits. No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.

V. Missed or Cancelled Appointments. Providers may charge You for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are provided for these charges. You are solely responsible for the charges.

W. Nutritional and/or Dietary Supplements. Except as provided in this Certificate or as required by law, no Benefits are available for nutrition and/or dietary supplements. This exclusion includes those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. Please see Section 4, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about Benefits for some of these items.

X. Physical Enhancement Services. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning or for pulmonary rehabilitation.

Y. Processing Fees. No Benefits are available for the cost of obtaining medical records or other documents that Anthem considers necessary to administer Benefits under this Certificate.

Z. Residential Accommodations. No Benefits are available for residential accommodations that provide care for medical or behavioral health conditions, except when provided by a hospital, hospice Provider, Skilled Nursing Facility, Residential Treatment Center, or other Inpatient facility specifically covered under this Certificate. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included;
- Care provided or billed by a hotel, health resort, spa, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution;
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included; or
- Wilderness or other outdoor camps and/or programs.

AA. Reversal of Voluntary Sterilization. No Benefits are provided for the reversal of sterilization, including infertility treatment that is needed as a result of a prior elective or voluntary sterilization (or elective sterilization reversal) procedure.

AB. Smoking Cessation Drugs, Programs or Services. No Benefits are available under this Plan for tobacco use and smoking and tobacco cessation programs, products, drugs or medications, hypnosis, supplies or devices of any kind intended to help You quit smoking or to wean You off nicotine. Such services are not covered, even if administered in a provider's office, ordered by a provider or if a provider's written prescription order is required for purchase of the service.

AC. Surrogate Parenting. No Benefits are available for costs associated with surrogate parenting or gestational carriers. Please see article I, E of this Section for detailed information.

AD. Travel Costs. No Benefits are available for mileage, lodging, meals, and other Member-related travel costs, except as specifically stated in this Certificate.

AE. Vein Treatment. Except when treatment is Medically Necessary as defined in Section 11 of this Certificate, no Benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including, but not limited to: ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of this Certificate because such treatment is considered to be cosmetic and not Medically Necessary.

AF. Wigs. No Benefits are available for hair prostheses (wigs) except as stated in Section 4, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics."

AG. Workers' Compensation. No Benefits are available for any condition, disease, or injury that arises out of or in the course of employment when You are covered by Workers' Compensation.

SECTION 6: CLAIMS PAYMENT

Please see Section 11 for Definitions of specially capitalized words.

This Section describes how Anthem reimburses claims and what information is needed when You submit a claim. This claims procedure does not apply to services paid or payable by Medicare. When You receive care from a Participating Provider, You do not need to file a claim because the Participating Provider will do this for You. If You receive care from a Nonparticipating Provider, You will need to make sure a claim is filed. Many Nonparticipating Providers will file Your claim for You, although they are not required to do so. If You file the claim, use a claim form as described later in this Section.

I. Maximum Allowed Amount

A. **General.** This article describes how Anthem determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Participating and Nonparticipating Providers is based on this Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please see "Inter-Plan Programs" later in this Section for additional information.

The Maximum Allowed Amount under this Certificate is the maximum amount of reimbursement the Plan will allow for services and supplies:

- That meet the definition of Covered Services, to the extent such services and supplies are covered under this Certificate and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable Preauthorization, utilization management or other requirements set forth in this Certificate.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. When You receive Covered Services from a Nonparticipating Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem's determination of the Maximum Allowed Amount. Anthem's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same doctor or other healthcare professional, Anthem may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

B. **Provider Network Status.** The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Nonparticipating Provider.

A Participating Provider is a Provider (as defined in Section 11) who is in the *managed network* for this specific health care plan or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with Anthem. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount under this Certificate is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Anthem Member Services at the telephone number on Your identification card for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Nonparticipating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain Providers. Nonparticipating Provider is defined in Section 11.

For Covered Services You receive from a Nonparticipating Provider, the Maximum Allowed Amount under this Certificate will be one of the following:

1. An amount based on Anthem's managed care fee schedules used with Participating Providers, which has been established at Anthem's discretion, and which Anthem reserves the right to modify from time to time; or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid services (CMS) for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (i) the complexity or severity of treatment; (ii) level of skill and experience required for the treatment; or (iii) comparable Providers' fees and costs to deliver care; or

4. An amount negotiated by Anthem or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this Plan, but are contracted for other health care plans with Anthem are also considered Nonparticipating Providers. Under this Certificate, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Nonparticipating Providers who are NonBluecard Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. Please call Anthem Member Services at the number on Your identification card for help in finding a Participating Provider or visit Anthem's website at www.anthem.com. Anthem Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from a Nonparticipating Provider. In order for Anthem to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of- Pocket responsibility. Although Anthem Member Services can assist You with this pre-service information, the

final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

C. Your Cost Share. For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance). Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Participating or Nonparticipating Provider. You may be required to pay higher cost sharing amounts or may have limits on Your Benefits when using Nonparticipating Providers.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Nonparticipating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of the Plan or received after Benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Benefit caps or day/visit limits.

In some instances You may only be asked to pay the Participating Provider cost sharing amount when You use a Nonparticipating Provider. For example, if You go to a Participating hospital or Provider facility and receive Covered Services from a Nonparticipating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with the Participating hospital or facility, You will pay the Participating Provider cost share amounts for those Covered Services.

Authorized Services. In some circumstances, such as where there is no Participating Provider available for the Covered Service, Anthem may authorize the Participating Provider cost share amounts (Deductible, Copayment or Coinsurance) to apply to a claim for a Covered Service You receive from a Nonparticipating Provider. In such circumstances, You or Your Provider must contact Anthem in advance of obtaining the Covered Service. If Anthem authorizes a Participating Provider cost share amount to apply to a Covered Service received from a Nonparticipating Provider, You may also be liable for the difference between the Maximum Allowed Amount and the Nonparticipating Provider's charge. Please contact Anthem's Member Services at the telephone number on Your identification card for additional information.

II. Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Nonparticipating Providers could be balanced billed by the Nonparticipating Providers for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

A. Post-Service Claims. A Post-Service Claim is any claim for a Benefit for which the terms of the Plan do not condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Post-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

1. Notice of Claim and Proof of Loss. After You get Covered Services, Anthem must receive written notice of Your claim in order for Benefits to be paid.

a. Participating Providers will submit claims for You. They are responsible for ensuring that claims have the information that Anthem needs to determine Benefits. If the claim does not include enough information, Anthem will ask them for more details, and they will be required to supply those details within certain timeframes.

b. Nonparticipating Provider claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Nonparticipating Provider is not submitting on Your behalf, You will be required to submit the claim. If the Provider does not have a claim form, please contact HealthTrust or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Anthem Member Services' telephone number is on Your identification card. Please complete the claim form, include Your itemized bill and any information about other insurance payment and submit the claim to the address indicated on the claim form.

If You are not able to contact HealthTrust or Anthem, or if HealthTrust or Anthem fails to furnish a claim form to You, written notice of the claim may be submitted to Anthem without the claim form. The time limit for submission will be met if You submit a written claim for Benefits within the time limit stated in this article. Your written claim for Benefits must include the same information that would be given on Anthem's prescribed claim form. This includes:

- Name of patient;
- Patient's relationship with the Subscriber;
- Identification number;
- Date, type, and place of service; and
- Your signature and the Provider's signature.

c. **Time Limit for Submitting Nonparticipating Provider Post-Service Claims.** In order for Anthem to make payments for Nonparticipating Provider Post-Service Claims, Anthem must receive Your claim for Benefits within 12 months after You receive the service. Otherwise, Benefits will be available only if:

- It was not reasonably possible to submit the claim within the 12-month period, and the claim is submitted as soon as reasonably possible after the 12-month period;
- An extension of the filing period is required by applicable law.

If the claim does not include enough information, Anthem will ask You for more details and inform You of the time by which Anthem needs to receive that information. Once Anthem receives the required information, Anthem will process the claim according to the terms of Your Plan. **Please note that failure to submit the information Anthem needs by the time listed in their request could result in the denial of Your claim, unless applicable law requires an extension.** Please contact Member Services if You have any questions or concerns about how to submit claims.

d. **Legal Action.** No action may be brought to recover Benefits for any service covered under this Certificate unless the required notice or proof of claim has been given to Anthem within the time frame required under this Certificate and such action is commenced no earlier than 60 days and no later than 2 years following the date that the notice or proof of claim has or should have been provided to Anthem.

2. **Timeframe for Post-Service Claim Determinations.** Anthem will make a Post-Service Claim determination within 30 days after receipt of the claim unless You or Your authorized representative fail to provide the information needed to make a determination. In the case of such failure, Anthem will notify You within 15 days after receipt of the claim. Anthem's notice will state the specific information needed to make a determination. You will be provided at least 45 days to respond to Anthem's notice. The period of time between the date of the request for information and the date of Anthem's receipt of the information is "carved out" of (does not count against) the 30-day time frame stated in this paragraph.

B. **Pre-Service Claims.** A Pre-Service Claim is any claim for a service with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the service. "Pre-Service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

1. **Pre-Service Claims May be Non-Urgent or Urgent.** An example of a non-urgent Pre-Service Claim is a request for Precertification of a scheduled Inpatient admission for elective surgery.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize Your life or health or Your ability to regain maximum function, or
- In the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the proposed care or treatment.

2. **Timeframes for Making Pre-Service Claim Determinations.** Anthem will make a determination about Your Pre-Service Claim within the following time frames. Time frames begin when Your claim is received and end when a determination is made.

- **For Non-Urgent Claims** a determination will be made within a reasonable time period, but in no more than 15 days after receipt of the claim. Exception: the initial 15 day period may be extended one time for up to 15 additional days, provided that Anthem finds that an extension is necessary due to matters beyond the control of Anthem. Before the end of the initial 15 day period, You will be notified of the circumstances requiring an extension. The notice will also inform You of the date by which a decision will be made. If the extension is necessary because You or Your authorized representative failed to provide the information needed to make a determination, the notice of extension will specify the additional information needed. You will be given at least 45 days from receipt of the notice to provide the specified information. The determination will be made as soon as possible, but in no case later than 15 days after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to You to provide the specified information.

- **For Urgent Care Claims** a determination will be made as soon as possible, taking into account the urgencies of Your medical condition, but no later than 72 hours after receipt of the claim. Exception: If You or Your authorized representative fail to provide the information needed to make a determination, Anthem will notify You within 24 hours after receipt of the claim. The notice will include the specific information necessary to make a determination. You will be given no less than 48 hours to provide the information. The determination will be made as soon as possible, but in no case later than 48 hours after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to You to provide the specified information.

- **For Urgent Care Claims Relating to *both* the Extension of an Ongoing Course of Treatment *and* a Question of Medical Necessity**, a determination will be made within 24 hours of receipt of the claim, provided that You make the claim at least 24 hours before the approved period of time or course of treatment expires.

No fees for submitting a Pre-Service Claim will be assessed against You or Your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or benefit determination by submitting Your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact Anthem Member Services at the number on Your identification card. Exception: For Urgent Care

Claims, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating physician) to be Your authorized representative without requiring Your written acknowledgment of the representation.

III. Notice of an Adverse Benefit Determination

Adverse Benefit Determination means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a individual's eligibility for coverage under this Certificate. Adverse Benefit Determination also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of utilization review procedures, as well as failure to cover a service for which Benefits are otherwise provided based on a determination that the service is Experimental, Investigational or not Medically Necessary or appropriate as well as, rescission of coverage.

Anthem's notice of a Post-Service or a Pre-Service Adverse Benefit Determination will be in writing or by electronic means and will include the following:

- The specific reason(s) for the determination, including the specific provision of Your Plan on which the determination is based;

- A statement of Your right to access the internal appeal process and the process for obtaining external review. In the case of an Urgent Care Adverse Benefit Determination or when the Adverse Benefit Determination is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, Anthem will include a description of the expedited review process;

- If the Adverse Benefit Determination is based upon a determination that the claim is Experimental or Investigational or not Medically Necessary or appropriate, the notice will include:

    - The name and credentials of Anthem's Medical Director, including board status and the state(s) where the Medical Director is currently licensed. If a person or other licensed entity making the Adverse Benefit Determination is not the Medical Director but a designee, the designee's credentials, board status, and state(s) of current license will be included, and
    - An explanation of the clinical rationale or the scientific judgment for the determination. The explanation will recite the terms of Your Plan or of any clinical review criteria or internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to Your specific medical circumstances.

- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Adverse Benefit Determination, a statement that such guideline was relied upon. A copy of the guideline will be included with the notice, or You will be informed that a copy is available free of charge upon request; and

- If clinical review criteria were relied upon in making any Adverse Benefit Determination, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale provided will be accompanied by the following notice: "The clinical review criteria provided to You are used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the Benefits covered under Your Certificate."

Anthem will not release proprietary information protected by third party contracts.

You may appeal any Adverse Benefit Determination. Please see Section 8 for information about how to use the appeal procedure.

IV. Member's Cooperation

You will be expected to complete and submit to Anthem all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate, You will be responsible for any charge for services. Please see Section 7, V, "Your Agreement and Responsibility Under This Certificate" for more information.

V. Payment of Benefits

Anthem will make payments directly to Participating Providers for Covered Services. If You use a Nonparticipating Provider, however, Anthem may make payments to You or the Nonparticipating Provider, at Anthem's discretion. In the event that payment is made directly to You, You have the responsibility to apply the payment to the claim from the Nonparticipating Provider. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Medical Child Support Order, as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by Anthem will discharge the Plan's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a Medical Child Support Order. Once a Provider performs a Covered Service, Anthem will not honor a request to withhold payment of the claims submitted.

VI. Inter-Plan Arrangements – Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Plan's Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating providers") don't contract with the Host Blue. The Plan's payment practices for both kinds of Providers are described below.

A. BlueCard® Program Under the BlueCard® Program, when You receive Out-of-Area Covered Services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for: (i) contracting with its Providers; and (ii) handling all interactions with its Participating Providers.

The BlueCard Program enables You to receive Out-of-Area Covered Services from a participating provider, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out.

Whenever You receive Out-of-Area Covered Services and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Occasionally, such an arrangement may be an average price, based on a discount that results in expected average

savings for similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

B. Special Cases: Value-Based Programs Under BlueCard® Program. If You receive Out-of-Area Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees. Federal or state laws or regulations may require the Host Blue to add a surcharge, tax or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

D. Nonparticipating Providers Outside the Plan's Service Area

1. **Allowed Amounts and Member Liability Calculation.** When Out-of-Area Covered Services are provided by Nonparticipating Providers, Anthem may determine Benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment Anthem will make for the Out-of-Area Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Care services.

2. **Exceptions.** In certain situations, Anthem may use other pricing methods, such as billed covered charges or the pricing Anthem would use if the healthcare services had been obtained within the Plan's Service Area, or a special negotiated price to determine the amount Anthem will pay for services rendered by Nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the Nonparticipating Provider bills and the payment Anthem makes for the Out-of-Area Covered Services as set forth in this paragraph.

SECTION 7: OTHER PARTY LIABILITY

Please see Section 11 for Definitions of specially capitalized words.

The following Coordination of Benefits (COB) guidelines and related other party liability rules apply to claims for Medicare Complementary Benefits and Major Medical Benefits that are submitted for payment under the Plan.

For purposes of Benefits under this Medicomp Three Certificate, Medicare shall be deemed to be Primary for Medicare Eligible Expenses, unless Medicare Secondary Payer rules require otherwise.

I. Coordination of Benefits (COB)

Coordination of Benefits sets the payment responsibilities when You are covered by more than one health care plan or policy. COB is intended to prevent duplication of payment and overpayments for Covered Services furnished to Members. If any Member is covered under another health care plan or policy, Benefits will be coordinated as stated in this Section.

For purposes of this Section only, "health care plan or policy" means any of the following, which provide benefits or services for, or by reason of, medical care or treatment:

- Group or individual hospital, surgical, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as "socialized medicine" plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits,

- Coverage under government plans or programs required or provided by any statute and in accordance with the limitations of the law. These include Medicare but do not include Medicaid.

- Except as stated in this Section, any insurance policy, contract or other arrangement or other insurance coverage, where a health Benefit is provided, arranged or paid, on an insured or uninsured basis,

- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

- The medical benefits coverage in automobile "no fault" or "personal injury protection" (PIP) type contracts, not including medical payments coverage, also known as part B in the personal automobile policy or med pay.

For purposes of this Section, the terms "health care plan" or "policy" do not refer to: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical payments coverage in a personal automobile policy, also known as Part B or med pay coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

The term "health care plan or policy" will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or

- That portion of any such policy, contract or other arrangement which reserves the right to take the benefits

of the other health care plan or policy into consideration in determining its benefits and that portion which does not take such benefits into consideration.

- The medical benefits coverage in automobile "no fault" or "personal injury protection" (PIP) type contracts, not including medical payments coverage, also known as Part B in the personal automobile policy or med pay.

COB also applies when You are covered by more than two policies.

Please remember that Your payments under this Certificate (such as Deductible and Coinsurance amounts that exceed the Maximum Allowed Amount, or any annual and lifetime maximums) are Your responsibility whether this Plan is Primary or Secondary. Also, other rules as stated throughout this Certificate (such as any applicable Provider network) apply whether this Plan is Primary or Secondary.

Please note: You may not hold or obtain Benefits under both this Plan and a nongroup (individual) health insurance policy issued by Anthem or any other insurer.

A. Definitions. The following definitions apply to the terms of this Section:

Primary means the health care plan or policy that is responsible for processing Your claims for eligible benefits first. When this Plan is Primary, this Plan will provide the full extent of Benefits covered under this Certificate, up to the Maximum Allowed Amount without regard to the possibility that another health care plan or policy may cover some expenses.

Secondary means the plan responsible for processing claims for Allowable Expenses after the Primary plan has issued a benefit determination. When this Plan is Secondary, Benefits under this Plan may be reduced so that payments from all health care plans or policies combined do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health care service expense that is eligible for Secondary Benefits under this health care Plan. Allowable Expenses include, but are not limited to, any deductible, coinsurance and copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

- An expense must be for a Medically Necessary Covered Service, as defined in this Certificate. Otherwise, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this Plan:

    a. If all plans covering the claim compute benefits or services based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.

b. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

c. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, and another plan computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans. Exception: If a Participating Provider contracts with Anthem to accept a negotiated amount as payment in full when this Plan is the Secondary payer and such negotiated amount differs from the Primary payer's arrangement, Anthem's negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed the Maximum Allowed Amount.

- If the Primary plan bases payment for a claim on the Provider's full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies or other similar reimbursement methodologies and does not negotiate fees with Providers, the combination of benefits paid by the Primary plan and this Plan will not exceed the Maximum Allowed Amount. The difference between the Maximum Allowed Amount and the Provider's charge is not an Allowable Expense.

- When benefits are reduced under a Primary plan due to an individual's failure to comply with the Primary plan's provisions, the amount of the reduction is not an Allowable Expense. Examples of these types of plan provisions include, but are not limited to: managed care requirements for second surgical opinions, Inpatient and Outpatient precertification requirements and rules about access to care (such as network restrictions and referral rules).

- Any expense that a health care Provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

B. The Order of Payment is Determined by COB. COB uses the following rules to determine the Primary and Secondary payers when You are covered by more than one health care plan or policy.

1. Important General Rules:

- **Services Outside the United States of America (U.S.A.).** If You have coverage under this Plan and any plan outside the U.S.A. (including plans administered by a government, such as "socialized medicine" plans), the out-of-country plan is Primary when You receive care outside the U.S.A. This Plan is Primary when You receive services in the U.S.A. This rule applies *before* any of the following rules (including the rules for children of separated or divorced parents).

- **Liability Laws.** To the extent permitted by applicable law, when any benefits are available as Primary benefits to a Member under Medicare (see article C "Medicare Program" below) or any Workers' Compensation Laws, Occupational Disease Laws or other employer liability laws, those benefits will be Primary.

- **No or Inconsistent COB Rule.** Except for group coverage that supplements a basic part of a benefit package and provides supplementary coverage (such as major medical coverage superimposed over base hospital/surgical coverage), any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this Section is always Primary.

2. **Order of Payment Rules.** If You are covered by more than one health care plan or policy and none of the "Important General Rules" listed above apply, the order of benefits will be determined by using the first of the following rules that apply:

- **Employee/Dependent Rule.** If You are the employee or Subscriber under one policy and You are a dependent under the other, the policy under which You are an employee or Subscriber is Primary. Exception: If You are a Medicare beneficiary and, as a result of federal law, Medicare is Secondary under the plan covering You as a dependent and Primary to the Plan covering You as an employee or Subscriber, then the order of benefits is reversed so that the plan covering You as an employee or Subscriber is the Secondary plan and the other plan is Primary.

- **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

  - For a dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:

    a. The plan of the parent whose birthday falls earlier in the calendar year is Primary, or

    b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.

  - For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of the court decree terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

    b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of the "birthday rule" (above) shall determine the order of benefits.

    c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of the "birthday rule" (above) shall determine the order of benefits.

    d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      - The plan covering the custodial parent;
      - The plan covering the spouse of the custodial parent;
      - The plan covering the non-custodial parent; and then
      - The plan covering the spouse of the non-custodial parent.

      A "custodial parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

    e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of 1 or 2 above shall determine the order of benefits as if those individuals were the parents of the child.

- **Active Employee or Retired or Laid-off Employee.** The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Employee/Dependent" rule (above) can determine the order of benefits.
- **COBRA or Other Continuation Coverage.** If a Member is covered under COBRA or a similar "right of continuation" law under either federal law or other continuation coverage, and the Member is also covered under another policy that is not a continuation policy, the continuation coverage is Secondary and the other plan is Primary. If the other plan does not have this rule and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Employee/Dependent" rule (above) can determine the order of benefits.
- **Longer/Shorter Length of Coverage**. The plan that covered the person as an employee, Member, policyholder, Subscriber or Retiree longer is Primary and the plan that covered the person the shorter period of time is Secondary.
- **If the preceding rules do not determine the order of benefits**, Allowable Expenses shall be shared equally between the health care plans or policies. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

C. **Medicare Program.** Coverage under this Plan is available only to Retirees and their family Members who are enrolled in Parts A and B of Medicare. For purposes of Benefits under this Medicomp Three Certificate, Medicare should be deemed to be Primary for Medicare Eligible Expenses, unless Medicare Secondary Payer rules require otherwise. The Secondary Benefits payable under this Plan will assume that You are eligible to receive both Medicare Part A and Part B benefits.

II. Workers' Compensation

No Benefits are available for any care, condition, disease or injury that arises out of or in the course of employment when You are covered by Workers' Compensation, unless You or Your employer waived coverage in accordance with New Hampshire law.

III. Subrogation and Reimbursement

These provisions apply when this Plan pays Benefits as a result of an injury, illness, impairment or medical condition You sustain and You have a right to a Recovery or have received a Recovery. For purposes of this Certificate, "Recovery" shall mean money You receive or are entitled to receive from another person, entity or any other source as a result of injury, illness, impairment or medical condition caused by another. Such payments shall include but are not limited to, any money from another, the other's insurer or from any "Home Owner's," "Uninsured Motorist," "Underinsured Motorist," "No-Fault," "Personal Injury Protection" or other insurance coverage or similar provision. These provisions do not apply to medical payments coverage, also known as Part B in a personal automobile policy or med pay. Regardless of how You or Your representative or any agreements characterize the Recovery You receive, it shall be subject to the Subrogation and Reimbursement provisions of this Section.

Benefits will be provided for medical care paid, payable or required to be provided under this Certificate, and the Benefits paid, payable or required to be provided. HealthTrust and/or Anthem must be reimbursed by the Member for such payments from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

Anthem may reduce any Benefit paid, payable or required to be paid under this Certificate by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including but not limited to automobile and homeowners' insurance coverage.

If benefits are exhausted under medical payments coverage or other similar property and casualty insurance, Benefits are available under this Plan, subject to all of the terms and conditions of this Certificate.

A. Subrogation. If You suffer an injury, illness, impairment or medical condition that is the result of another party's actions, and this Plan pays Benefits to treat such injury, illness, impairment or medical condition, HealthTrust will be subrogated to Your Recovery rights. HealthTrust, and/or Anthem acting on HealthTrust's behalf, may proceed in Your name against the responsible party. Additionally, HealthTrust and/or Anthem acting on HealthTrust's behalf shall have the right to recover payments this Plan makes on Your behalf from any party responsible for compensating You for Your injury, illness, impairment or medical condition. All of the following shall apply, except to the extent limited by applicable law:

- HealthTrust and/or Anthem acting on HealthTrust's behalf may pursue HealthTrust's subrogation rights and have first priority for the full amount of Benefits this Plan has paid from any Recovery regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses and injuries.

- You and Your legal representative may not waive or otherwise prejudice in any way HealthTrust's subrogation rights set forth in this Section. You and Your legal representative must do whatever is necessary to enable HealthTrust and/or Anthem to exercise such rights.

- HealthTrust and/or Anthem have the right to take whatever legal action they see fit against any party or entity to recover Benefits paid under this Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full HealthTrust's and/or Anthem's subrogation claim and any claim still held by You, HealthTrust's and/or Anthem's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- This Plan, HealthTrust and Anthem are not responsible for any attorney fees, other expenses or costs You incur without the prior written consent of HealthTrust. Further, the "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

Nothing in this Section shall be construed to limit the Plan's, HealthTrust's and/or Anthem's right to utilize any remedy provided by law to enforce HealthTrust's rights to subrogation under this Section. HealthTrust and/or Anthem, acting on its behalf, is entitled to reimbursement from the responsible party or any other party You receive payment from to the extent of Benefits provided. HealthTrust and/or Anthem reserves the right to compromise on the amount of the claim if HealthTrust and/or Anthem, acting on its behalf, determines that it is appropriate to do so. Any action that interferes with HealthTrust's subrogation rights may result in the termination of coverage for the Subscriber and covered dependents.

B. Reimbursement. If You obtain a Recovery and HealthTrust and/or Anthem have not been repaid for the Benefits this Plan paid on Your behalf, HealthTrust and/or Anthem shall have a right to be repaid from the Recovery up to the amount of the Benefits paid on Your behalf. All of the following shall apply, except to the extent limited by applicable law:

- HealthTrust and/or Anthem are entitled to reimbursement from any Recovery, in first priority, notwithstanding any allocation made in a settlement agreement or court order, and even if the Recovery does not fully satisfy a judgment, settlement or underlying claim for damages or fully compensate or make You whole.

- You and Your legal representative must hold in trust for HealthTrust and/or Anthem the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to HealthTrust and/or Anthem immediately upon Your receipt of the Recovery. You must fully reimburse HealthTrust and/or Anthem, in first priority and without any offset or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

- This Plan shall be entitled to deduct any of the unsatisfied portion of the amount of Benefits paid by the Plan or the amount of Your Recovery, whichever is less, from any future Benefits under the Plan if:

    1. You fail to disclose to HealthTrust and/or Anthem the amount of Your Recovery;

    2. The amount this Plan paid on Your behalf is not repaid or otherwise recovered by HealthTrust and/or Anthem; or

    3. You fail to cooperate with HealthTrust and/or Anthem

- HealthTrust and/or Anthem shall also be entitled to recover any of the unsatisfied portion of the amount paid by the Plan or the amount of Your Recovery, whichever is less, directly from the Providers to whom payments have been made. In such a circumstance, it may then be Your obligation to pay the Provider the full amount billed by the Provider, and the Plan would have no obligation to pay the Provider.

IV. HealthTrust's and Anthem's Rights Under this Certificate

A. General. HealthTrust, and/or Anthem acting on HealthTrust's behalf, reserves the right to:

- Take any action needed to carry out the terms of this Section and the Certificate,
- Exchange information with other insurance companies and/or other parties,
- Recover any excess payment made under this Plan from another party or reimburse another party for its excess payment, and
- Take the actions set forth in this Section when necessary without notifying the Member.

This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information. Neither does this provision permit the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been paid by this Plan, Anthem, on behalf of the Plan, has the right to pay the other plan or entity any amount that Anthem determines in its discretion to be warranted to satisfy the intent of this Section. Amounts so paid are Benefits under this Certificate and, to the extent of such payments, the Plan, HealthTrust and Anthem are fully discharged from liability under this Certificate.

If the Plan has provided Benefits subject to reimbursement or subrogation and You recover payments from another source which You do not pay to HealthTrust and/or Anthem, HealthTrust and/or Anthem has the right to offset these amounts against any other amount that would otherwise be payable under this Certificate.

B. Mistaken Payments and Right of Recovery. On occasion, a payment may be made by the Plan to You or on Your behalf in error (for example, when You are not covered, for a service which is not covered, or which is more than is appropriate for the service). Whenever a payment has been made in error, HealthTrust and/or Anthem acting on HealthTrust's behalf, has the right to recover such payment from You or any Member, Provider, or other person or entity to whom or for whom such payment was made. The right of recovery may result in an adjustment to the claim. Anthem is given the right to deduct or offset any amounts paid in error by the Plan from any pending or future claim. Anthem has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses, and when to settle or compromise recovery or adjustment amounts. In most instances, recovery or adjustment activity will occur within 12 months of the date of a payment made. Recovery or adjustment can occur beyond 12 months in certain circumstances when, for example, the claim payment was made incorrectly, the healthcare was not delivered by the Provider, or the claim was submitted fraudulently. The Plan will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

V. Your Agreement and Responsibility Under This Section

You have the responsibility to provide prompt, accurate and complete information to HealthTrust and Anthem about other health care plans and/or insurance policies or benefits You may have in addition to Your HealthTrust coverage. Other health care plans, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Medicare, Workers' Compensation, and/or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition You receive. By accepting this Certificate, You agree to cooperate with HealthTrust and Anthem, and You agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Section. By accepting this Certificate You agree to:

- Promptly notify HealthTrust and/or Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to You occurred and all information regarding the parties involved,
- Cooperate with HealthTrust and/or Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice the rights of HealthTrust and Anthem,
- Send to HealthTrust and/or Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to You, and
- Promptly notify HealthTrust and/or Anthem if You retain an attorney or if a lawsuit is filed on Your behalf.

Any action which interferes with HealthTrust's rights under this Section or the Certificate may result in the termination of coverage for the Subscriber and covered dependents.

Please call Anthem Member Services at the number on Your identification card if You have questions about any portion of this Section.

SECTION 8: MEMBER SATISFACTION SERVICES, INTERNAL APPEAL PROCEDURE AND EXTERNAL REVIEW

Please see Section 11 for Definitions of specially capitalized words.

This Section explains how to contact HealthTrust or Anthem when You have questions, suggestions, concerns or complaints regarding Your Medicomp Three Benefits. Please note that oral statements by agents or representatives of HealthTrust or Anthem do not change the Benefits described in this Certificate.

I. Member Satisfaction Services

HealthTrust and Anthem provide quality Member satisfaction services through their respective Enrollee Services and Member Services. All HealthTrust and Anthem personnel are responsible for addressing Your concerns in a manner that is accurate, courteous, respectful and prompt. Service Representatives are available to:

- Answer questions You have about Your membership, Your Benefits, Covered Services, Participating Providers, payment of claims, and about policies and procedures,
- Provide information or Plan materials that You want or need,
- Make sure Your suggestions are brought to the attention of the appropriate persons at HealthTrust or Anthem, and
- Provide assistance to You (or Your authorized representative) when You want to file an internal appeal.

HealthTrust and Anthem use Your identification number to locate Your important records with the least amount of inconvenience to You. Your identification number is on Your identification card. Please be sure to include Your entire identification number (with the three-letter prefix) when You call or write.

We want Your experience with us to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. HealthTrust or Anthem will try to resolve Your inquiry informally. If You are not satisfied with the response provided, You have the right to file an appeal. Please see articles II and III of this Section for information about appeals procedures.

If You have a concern about the quality of care offered to You by a Participating Provider (such as waiting times, Provider behavior or demeanor, adequacy of facilities or other similar concerns), You are encouraged to discuss Your concerns directly with the Provider before You contact an Anthem Member Services Representative.

Please contact **HealthTrust** about Your enrollment, wellness programs, or Plan materials. Call HealthTrust Enrollee Services at: **1-800-527-5001.** Or, You may write to:

HealthTrust
PO Box 617
Concord, NH 03302-0617

Please contact **Anthem's Member Services** about Your Benefits, Covered Services, Plan materials, or Participating Providers. Call Anthem at the telephone number on Your identification card**.** Or, You may write to:

Member Services
Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660

II. Internal Appeal Procedure

You have the right to receive Benefits as described in this Certificate. You may appeal any Adverse Benefit Determination made by Anthem. This Section explains the Internal Appeal procedure. **You or Your authorized representative must file Your appeal within 180 days after You are notified of the Adverse Benefit Determination.** Please see Section 6, III, "Notice of an Adverse Benefit Determination."

By accepting this Certificate, You agree that You will take no court action related to Your coverage or Benefits under the Plan before completing the steps described below. Your obligations under this Certificate are fulfilled when the first level internal appeal procedure is completed as stated in this article. A voluntary second level of internal appeal, which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal, is also available as stated in this article. The time frame allowed for Anthem to complete its review is dependent upon the type of review involved (e.g., pre-service, urgent, concurrent, post-service, etc.).

Please see Section 11 for definitions of "Adverse Benefit Determination", "Urgent Care Claim", "Pre-Service Claim" and "Post-Service Claim."

Internal appeals are conducted and overseen by Anthem. No fees for submitting an appeal will be assessed against You or Your authorized representative.

Who may submit an internal appeal? You or Your authorized representative may submit an internal appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact Anthem's Member Services at the telephone number on Your identification card. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating Provider) to be Your authorized representative without requiring Your written acknowledgment of the representation; or

- A court order is in effect authorizing the person to act on Your behalf, and a copy of the order is on file with Anthem.

What should be included with an internal appeal? You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. Anthem's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination. Please include Your identification number (including the three-letter prefix) and describe the services that You are submitting for review. If possible, refer to the date You received the service and state the name of the doctor, hospital or other Provider that furnished the care. You may also want to include:

- Bills that You have received from the Provider;

- Any information that You believe is important for review, such as statements from Your physician or letters You received from Anthem; and

- A reference to the portion of this Certificate that You believe pertains to Your appeal. You should state the outcome You are expecting as a result of Your appeal.

Anthem may ask You to sign an authorization so that medical records can be obtained to conduct the appeal.

A. First Level Appeal. To exercise Your right to a first level internal appeal, please take the following steps:

Expedited Appeals. For Pre-Service Claims involving an Urgent Care/concurrent care Claim, or concurrent care claim denial, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method.

To file an appeal for an Urgent Care Claim or concurrent care claim denial, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

Non-Expedited Appeals. All other requests for appeals should be submitted in writing, unless Anthem determines that it is not reasonable to require a written statement. You or Your authorized representative must submit a request for review to:

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

Anthem will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an Adverse Benefit Determination or review based on a new or additional rationale, Anthem will provide You, free of charge, with the rationale.

How Your Appeal will be Decided. When Anthem considers Your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Timeframes for First Level Appeal Determinations. Anthem will notify You of the outcome of Your appeal in the following timeframes:

- **For an appeal of a Pre-Service Claim involving an Urgent Care Claim or concurrent care claim (Expedited Appeal)**, Anthem will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

- **For an appeal of any other Pre-Service Claim**, Anthem will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

- **For an appeal of a Post-Service Claim**, Anthem will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Content of Notice of an Appeal Determination. You will be notified in writing of the appeal determination. If the denial of Benefits is upheld, in whole or in part, the written denial notice will be considered an Adverse Benefit Determination and will include the following:

- The specific reason(s) for the determination, including reference to the specific provision of this Certificate on which the determination is based;

- If an internal rule, guideline, protocol or other similar provision was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar provision was relied upon; and

- If the determination is based upon a finding that the service under appeal is Experimental, Investigational or not Medically Necessary or appropriate, the notice will include:

    - The name and credentials of the person reviewing the appeal, including board status and the state or states where the person is currently licensed;

    - An explanation of the clinical rationale for the determination. This explanation will recite the terms of this Certificate or of any clinical review criteria or any internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to Your specific medical circumstance;
    -
    - A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (such as copies of rules, guidelines, protocols or other similar criterion upon which the Adverse Benefit Determination is based) relevant to Your claim for Benefits. The records on file with Anthem may be limited in scope. Please contact Your physician if You have questions or concerns about the content of Your medical records; and

    - A statement describing all other dispute resolutions options available to You, including but not limited to Your options for a second level internal appeal, External review or for bringing a legal action.

B. Voluntary Second Level Appeal. If You are not satisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. You are not required to complete a voluntary second level appeal prior to submitting a request for independent External Review. If You would like to initiate a second level appeal, please submit Your request to Anthem at:

Appeals Department
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

Your appeal must be in writing unless Anthem determines that it is not reasonable to require a written statement. For example, expedited appeals may be submitted orally or in writing. **Your appeal must be submitted within at least 180 days of Anthem's notice stating the results of Your first level internal appeal.** You do not have to re-send the information that You submitted for Your first level internal appeal. However, You are encouraged to submit any additional information that You think is important for review. If Anthem finds that more information is required in order to conduct Your appeal, You will be notified in writing as soon as possible.

A voluntary second level review will be conducted by an appropriate reviewer who did not make the initial determination or the first level appeal determination and who does not work for the person who made the initial determination or first level appeal determination.

Timeframes for Voluntary Second Level Appeal Determinations. Anthem will complete a voluntary second level appeal within 45 business days after receiving all the information necessary to complete the review.

III. External Review for Major Medical Benefits

If the outcome of the mandatory first level appeal and/or voluntary second level internal appeal is based on medical judgment and adverse to You, You may be eligible for an independent External Review pursuant to federal law. There is no charge for You to initiate an independent External Review. This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other Benefits under this Plan. The External Review decision is final and binding on all parties except that it does not prevent You from pursuing any other remedy You may have under this Plan or at law.

You must submit Your request for External Review to Anthem **within four (4) months** of the notice of Your final internal Adverse Benefit Determination. A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal(s). However, You are encouraged to submit any additional information that You think is important for review.

Expedited External Review. For Pre-Service Claims involving Urgent Care Claim or concurrent care claim denials You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method.

To proceed with an Expedited External Review, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

Non-Expedited External Review. All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

HealthTrust and Anthem reserve the right to modify the policies, procedures and timeframes in this Section upon further clarification from the Department of Health and Human Services or the Department of Labor.

IV. Requirements Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure (but not including any voluntary second level of appeal) before filing a lawsuit or taking other legal action related to Your coverage or Benefits under the Plan.

V. Disagreement With Recommended Treatment

Your Provider is responsible for determining the health care services that are appropriate for You. You may disagree with Your Provider's decisions and You may decide not to comply with the treatment that is recommended by Your Provider. You may also request services that Your Provider feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, You have the right to refuse the recommendations of Your Provider. In all cases, Anthem, on behalf of HealthTrust, has the right to deny Benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Certificate or is otherwise not covered under the terms of this Certificate.

SECTION 9: GENERAL PROVISIONS

Please see Section 11 for Definitions of specially capitalized words.

I. Amendment and Termination

HealthTrust may amend or modify the Plan or this Certificate through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to You and all other Members. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. HealthTrust reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

II. Applicable Law

The Plan and this Certificate shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

III. Waiver of Rights

On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of this Certificate; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Anthem has the right to change or waive any of the provisions of this Certificate without the approval of an authorized executive of HealthTrust.

IV. HealthTrust and Anthem are not Responsible for Acts of Providers

HealthTrust and Anthem are not liable for the acts or omissions of any individuals or institutions furnishing care or services to You.

V. Rights to Administer Plan

HealthTrust reserves the right to determine eligibility for participation in this Plan. Anthem, as delegated by HealthTrust, or anyone acting on Anthem's behalf, shall determine the administration of Benefits in such a manner that has a rational relationship to the terms set forth herein. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental or Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. However, a Member may utilize all applicable appeals procedures.

HealthTrust and Anthem, or anyone acting on their behalf, shall have all the powers necessary or appropriate to enable them to carry out their respective duties in connection with the operation and administration of the Plan and this Certificate. This includes, without limitation, the power to construe the Certificate, to determine all questions arising under the Certificate and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general Benefit language.

VI. Limitation on Enforcement of This Certificate

No person or entity, other than HealthTrust, Anthem or a Member is, or will be, entitled to bring any action to enforce any provision of this Certificate against HealthTrust, Anthem or a Member. The covenants, undertakings and agreements set forth in this Certificate will be solely for the benefit of, and will be enforceable only by, HealthTrust, Anthem and the Member covered under this Certificate.

VII. Confidentiality and Privacy

HealthTrust and Anthem undertake efforts to safeguard the privacy and confidentiality of Your personal health information in accordance with state and federal laws regarding privacy of personal and health information. HealthTrust's Notice of Privacy Practices, which describes HealthTrust's privacy practices, is available on HealthTrust's website at *www.healthtrustnh.org.* To request a copy of the Notice, or if You have questions about the privacy of Your personal and health information, please contact HealthTrust as follows:

Privacy Officer
HealthTrust, Inc.
PO Box 617
Concord, NH 03302-0617
800-527-5001 or
603-226-2861 (Local)
privacyofficer@healthtrustnh.org

VIII. Acknowledgement of Understanding

It is expressly acknowledged and understood that the administrative services provided by Anthem for You, Your Group, and HealthTrust are subject to an agreement between Anthem and HealthTrust, and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield name and marks in the State of New Hampshire. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C., and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This provision shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under the provisions of this Certificate and the agreement between Anthem and HealthTrust.

IX. Right of Offset

HealthTrust reserves the right to empower Anthem to offset any amounts owed to the Plan by a Member against any amounts due from the Plan to such Member or any other Member receiving Benefits through the same Subscriber.

X. Separability Clause

If any provision of this Certificate is invalid or unenforceable under any applicable statute or rule of law, then the affected provision shall be curtailed and limited only to the extent necessary to bring the provision within the applicable legal requirements and this Certificate as so modified shall continue in full force and effect.

XI. Spendthrift Provision

The right to receive Major Medical Benefits under the Plan shall not be assignable, or subject to attachment or receivership, nor shall it pass to any trustee in bankruptcy, or be reached or applied by any legal process for the payment of any applications of the Member.

XII. Non-ERISA Governmental Plan

The Plan is a governmental plan established and maintained by HealthTrust and Your Group, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974 (ERISA).

XIII. Headings, Pronouns and Cross References

Section and article headings contained in this Certificate are inserted for convenience of reference only, will not be deemed to be a part of this Certificate for any purpose, and will not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

All pronouns and any variations thereof will be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

In this Certificate, You find "cross references." For example, when You review Section 4, please also refer to Section 5 for "Limitations and Exclusions." These cross references are for Your convenience only. Cross references are not intended to represent all of the terms, conditions and limitations set forth in this Certificate.

SECTION 10: ELIGIBILITY, ENROLLMENT, TERMINATION OF COVERAGE AND CONTINUATION OF COVERAGE

Please see Section 11 for Definitions of specially capitalized words.

I. Eligibility

You must meet Your Group's and HealthTrust's eligibility rules and the terms set forth in this Certificate to be eligible to enroll in the Plan. Please contact Your Group for information about the Group's specific eligibility rules.

No person who is eligible to enroll will be denied enrollment based on health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or gender identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

Coverage under this Plan is made available to You as a Subscriber because of Your or Your family member's retirement from the Group. Coverage is available only to Retirees and their family members who are enrolled in Parts A and B of Medicare and who the Group determines are eligible under the Plan in accordance with applicable rules and procedures of the Group and HealthTrust. Coverage is provided on a Subscriber only basis, so that each eligible individual is a separate Subscriber under this Plan. Eligibility requirements for Subscribers are described in general terms below. For more specific eligibility or other information about Your Group's Retiree coverage, please contact the Group Benefits Administrator.

This Plan does not provide coverage for Retirees or family members who are not enrolled in Medicare. However, those individuals may be entitled to coverage under another group health plan offered by Your Group. Please contact the Group Benefits Administrator for more information.

A. Subscriber. To be eligible to enroll for coverage under the Plan as a Subscriber, You must:

1. Be a Retiree as defined in Section 11, the spouse of a Retiree, or a disabled dependent child of a Retiree;

2. Be entitled to Medicare benefits due to age, disability or End Stage Renal Disease;

3. Be enrolled under Parts A and B of Medicare;

4. Not be enrolled in a Medicare + Choice Plan or any other coverage that is supplemental to Parts A and B of Medicare; **and**

5. Be certified by Your Group as being eligible for coverage under the Plan.

B. Spouse of a Retiree. For information on spousal eligibility, please contact the Group. For purposes of requirement (1) above, if the Group offers spousal coverage, the Retiree's spouse is eligible to enroll unless the parties are divorced or legally separated. Throughout this Certificate, any reference to "spouse" means:

- The individual to whom the Retiree is lawfully married, as recognized under state or federal law. This includes same sex spouses when legally married in a state that recognizes same sex marriage; or
- The individual with whom the Retiree has entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this Certificate any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a lawful marriage or lawful civil union. Coverage is available for same-sex or opposite-sex Domestic Partners (including "common law" type relationships and other unmarried couples) **only if** Your Group has elected a Domestic Partner Rider and **only if** all of the criteria for membership are met, as stated in the Domestic Partner Rider.

C. **Disabled Dependent Child of a Retiree.** For purposes of (1) above, "disabled dependent child of a Retiree" includes any of the following dependent children of a Retiree or a Retiree's spouse who are entitled to Medicare benefits due to disability or End Stage Renal Disease, provided that coverage for such children is offered by the Group:

- **Dependent Children Under 26 Years of Age.** "Children" include: natural children, stepchildren, legally adopted children, children for whom You are the proposed adoptive parent and who have been placed in Your custody pursuant to an adoption proceeding under the provisions of New Hampshire law before the adoption becomes final, children for whom You are the legal guardian including children for whom You were the legal guardian at the time the child attained 18 years of age **and** the legal guardianship terminated by operation of NH RSA 463:15(I), and children for whom there is a Medical Child Support Order in effect, or as otherwise required by law. Foster children and grandchildren are not eligible for coverage unless they meet the definition of "children" above.

  A married or unmarried dependent child who meets the above definition is eligible to enroll as a Subscriber under this Plan.

- **Unmarried Incapacitated Dependent Child Age 26 or Older**. An unmarried child 26 years of age or older and physically or mentally incapable of self-support (as certified by a physician), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above. The physical or mental incapacity must have occurred *before* the child reached age 26 and must have occurred while the dependent was a covered dependent child. Incapacitated dependents may remain covered as long as their disability and Medicare eligibility continues and as long as they are financially dependent on the Retiree and are incapable of self-support. HealthTrust must receive an application for the incapacitated dependent child status and medical certification of the incapacity by a physician within 31 days of the date coverage would otherwise end for the child. Anthem's Medical Director must certify the dependent child's incapacitated status and HealthTrust will periodically request that the incapacitated status of the child be recertified.

D. **Accuracy and Verification of Enrollment Information.** By accepting this Certificate, You represent that all statements made in Your Medical Enrollment Application, or any other documentation You provide with respect to eligibility and enrollment are true to the best of Your knowledge and belief. You agree to give HealthTrust information that HealthTrust deems necessary to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide membership eligibility are information regarding: Retiree status, Medicare enrollment (in both Parts A and B), incapacitated child status, marital status, divorce or legal separation. HealthTrust reserves the right to deny enrollment or cancel a Retiree's or a Retiree's family member's coverage under the Plan to the extent permitted by law if You fail to provide verification upon request or misrepresent the eligibility status of You or any family member.

Rescission. HealthTrust may terminate a Member's coverage back to the original effective date for any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact on the part of a Member.

II. Enrollment and Effective Date of Coverage

A. Initial Enrollment. If the eligibility requirements described in article I of this Section have been satisfied, the eligible Retiree or other family member may enroll in the Plan by submitting a Medical Enrollment Application and a copy of Your Medicare card showing coverage effective for both Parts A and B to the Group Benefits Administrator. The Medical Enrollment Application should be submitted as soon as possible once the eligibility requirements have been satisfied. Coverage will become effective as of the first day of the calendar month coincident with or next following Your eligibility date as determined mutually by Your Group and HealthTrust in accordance with applicable rules and procedures of HealthTrust. In general, Your eligibility date will be the later of (i) the Retiree's date of retirement from the Group or (ii) the date You first become entitled to Medicare benefits, provided all other eligibility requirements are then satisfied. An applicant is considered enrolled only upon acceptance of the Medical Enrollment Application by HealthTrust. If a Medical Enrollment Application is not submitted within the timeframes required by HealthTrust when a Retiree first becomes eligible, the Retiree may not enroll at a later date, except during a special enrollment period as described in the following paragraph. If an Application is not submitted within the timeframes required by HealthTrust when a Retiree's spouse or disabled dependent child first becomes eligible, the family member may not be enrolled at a later date, except during an open enrollment period or special enrollment period as described below. Please contact the Group Benefits Administrator or HealthTrust for more information about initial enrollment rules.

B. Special Enrollment for a Retiree (and Eligible Family Members). As a general rule, a Retiree who does not elect to enroll in this Plan upon initial eligibility, or who terminates participation at any time after initial enrollment, will not be eligible to enroll in the Plan at any later date. In certain limited circumstances, however, late initial enrollment by a Retiree (and eligible family members) or reinstatement to coverage under the Plan for a previously enrolled Retiree (and eligible family members) may be permitted in accordance with applicable rules and procedures of the Group and HealthTrust. For example, if a Retiree declines or terminates enrollment under this Plan because of coverage under another employer group health plan, the Retiree in certain circumstances may be entitled to enroll in this Plan in the future upon an involuntary loss of such other coverage. Please contact the Group Benefits Administrator or HealthTrust for more information on the special enrollment and Retiree coverage rules.

C. Special Enrollment for Newly Eligible Family Members. This Plan provides coverage only for individual Subscribers. No dependent coverage is offered and no coverage for family members who are not entitled to Medicare benefits is available under this Certificate. If a Retiree who is enrolled under this Plan or another health plan offered by the Group has a newly eligible family member (such as a new spouse, a spouse newly eligible for Medicare, or a newly disabled dependent child), the Retiree may enroll the newly eligible family member as a Subscriber under this Plan by submitting a Medical Enrollment Application and a copy of the Medicare card showing coverage effective for both Parts A and B to the Group Benefits Administrator within 31 days after the spouse or disabled dependent child first becomes eligible. Provided HealthTrust receives the Application within 31 days of eligibility, coverage of the family member as a Subscriber will become effective as of the first day of the month following his/her eligibility date. A newly eligible family member is considered enrolled only upon acceptance of the Medical Enrollment Application by HealthTrust. If a Medical Enrollment Application is received by HealthTrust after 31 days, but within 60 days, from the date Your spouse or disabled dependent child first become eligible, the coverage will become effective the first day of the month following receipt of the Application. If an Application is not received within 60 days, the newly eligible spouse or disabled dependent child may not be enrolled until the next open enrollment period.

If a Retiree enrolled in this Plan has a new family member (such as a new spouse, newborn child or adopted child) who is not then eligible for Medicare, the Retiree may have the right to enroll the new family member in another health plan offered by the Group in accordance with applicable rules and procedures of the Group and HealthTrust. Please contact the Group Benefits Administrator for more information.

D. **Open Enrollment for Eligible Family Members.** There will be an annual open enrollment period as determined by Your Group for eligible family members of a Retiree who is enrolled under this Plan or another health plan offered by the Group. Open enrollment is generally a period of 30 to 60 days prior to Your Group's Anniversary Date (either January 1 or July 1) each year, and also may include the month of Your Group's Anniversary Date. If a Medical Enrollment Application is received by HealthTrust on or before the last day of the month of Your Group's Anniversary Date, coverage will be effective as of either the Anniversary Date or the first of the month following receipt of the Application, as determined by Your Group. If, however, the Medical Enrollment Application is not received by HealthTrust by the end of the month of Your Group's Anniversary Date, the requested enrollment may not be made until the next open enrollment period or special enrollment period.

If a Retiree enrolled in this Plan has a family member who is not eligible for Medicare, the Retiree may have the right to enroll the family member in another health plan offered by the Group in accordance with applicable rules and procedures of the Group and HealthTrust. Please contact the Group Benefits Administrator for more information.

E. **Additional Rules.** The following rules apply in addition to those described above:

1. **Your Responsibility to Provide Notice of Changes.** It is Your responsibility to inform Your Group and HealthTrust of changes in Your name or address. It is also the Retiree's responsibility to inform Your Group and HealthTrust if an eligible family member needs to be added as a Subscriber or when a family member is no longer eligible for coverage under the Plan. Notice requirements regarding continuation coverage election are stated in article IV of this Section.

   Name changes and enrollment changes must be made through the Group Benefits Administrator. You will be required to sign a Medical Enrollment Application in order to effect the change. Failure to timely notify Your Group Benefits Administrator of changes in the eligibility status of You or any of Your eligible family members may result in a cancellation of coverage or delay in enrollment for You or Your family members.

   For a change of address, contact Your Group Benefits Administrator or HealthTrust at:

   HealthTrust
   P.O. Box 617
   Concord, NH 03302-0617
   1-800-527-5001

2. **Disclosing Coverage.** As another condition of enrollment and coverage under the Plan, You agree to provide information to Your Group and HealthTrust regarding any other health coverage under which You may be entitled to benefits. Your receipt of benefits through another health care plan may affect Your Benefits under this Certificate. Please see Section 7 for more information about how Benefits are determined when You are covered under more than one health plan.

III. Termination of Coverage

A. **General.** This article describes circumstances under which Your coverage under the Plan will terminate. Whether or not You or Your Group contacts HealthTrust to effect any of the terminations in this article, HealthTrust will administer the terminations if HealthTrust has knowledge of the termination event. Subject to any right to continuation of coverage as described in article IV of this Section, Benefits under this Certificate, including Benefits for services rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate at midnight on the earliest of the dates

specified below. In no event are Benefits available for Covered Services rendered or delivered after the date coverage under the Plan terminates.
Enrollment under the Plan will not be terminated solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

Under certain circumstances, You may be entitled to continue coverage under the Plan (or convert to an individual policy). Please see article IV below for more information.

B. Termination Events and Dates. Coverage will automatically terminate at midnight on the earliest of the following dates:

- The date this entire Plan is terminated by HealthTrust. HealthTrust may, at its discretion at any time, discontinue this Plan as long as You and Your Group are given 30 days advance notice;
- The date as of which Your Group terminates Your Group's (or a subunit of Your Group) participation in the Plan;
- The end of the month in which You no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which the Group Benefits Administrator notifies HealthTrust to terminate Your coverage;
- The date specified by HealthTrust that Your coverage will end because You or Your Group failed to pay any required premium or other contribution for Your coverage under the Plan;
- The date of Your enrollment (or such other date as specified by HealthTrust and allowed by law) if HealthTrust or Anthem determines that You have engaged in any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact related to Your eligibility or enrollment, on, or with respect to, the Medical Enrollment Application or other required documentation in obtaining or maintaining coverage under the Plan;
- The date HealthTrust determines that You have failed to comply with the procedures and requirements set forth under the provisions of Section 7 "Other Party Liability" of this Certificate;
- The date specified by HealthTrust in a notice of cancellation or nonrenewal of Your Group's participation in the Plan or in HealthTrust, sent to Your Group by HealthTrust, due to Your Group's failure to meet HealthTrust's minimum employee participation requirements or other requirements under the Group's participation agreement with HealthTrust; or
- The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other health plan coverage, fraud committed by a Subscriber in connection with any claim filed under this Certificate, or if an unauthorized person is allowed to use any Subscriber's identification card or if a Subscriber otherwise cooperates in the unauthorized use of such Subscriber's identification card.

C. Additional Rules for Certain Termination Events. The following additional rules apply with respect to certain termination events:

1. Your Death. Your coverage will terminate on the date of Your death. Please see article IV of this Section for information about how covered surviving spouses and covered disabled dependent children may be entitled to continue coverage following the death of the Retiree.

2. **Termination of Your Marriage.** If You are the spouse of a Retiree and You become divorced or legally separated from the Retiree, Your coverage under this Plan will terminate at the end of the month which includes the date of divorce or legal separation. The Retiree must submit a Medical Enrollment Application indicating a change in marital status within 31 days of such change. However, the Retiree's failure to submit an Application does not prohibit Your Group or HealthTrust from terminating Your enrollment if You no longer meet the definition of a covered spouse. Please see article IV of this Section for information about how a Retiree's spouse may be entitled to continue coverage after a divorce or legal separation.

3. **Termination of a Disabled Dependent Child's Coverage.** If You are a disabled dependent child covered under this Plan, Your coverage will terminate at the end of the month which includes the date on which You no longer meet the eligibility requirements for a disabled dependent child as set forth in article I of this Section. A Medical Enrollment Application must be submitted within 31 days of such change. Please see article IV of this Section for information about how You may be entitled to continue coverage.

IV. Continuation of Group Coverage

This article explains some of the ways a Retiree's covered family members can choose to continue coverage through Your Group when coverage would otherwise end. A separate document which describes these continuation rights in further detail is provided to You upon initial enrollment in the Plan.

A. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA is a federal law which requires Your Group to offer Subscribers who are enrolled family members of a Retiree the opportunity to continue coverage under the Plan for a temporary period, at the individual's expense, when Benefits would otherwise end because of certain "qualifying events." For this purpose, qualifying events include the Retiree's death, legal separation, divorce, or a disabled dependent child losing eligibility status under the Plan. COBRA continuation rights under the Plan are available only through the Retiree's group. HealthTrust assists the Group with certain COBRA notices and other administrative requirements.

1. **Qualifying Events.** Subscribers who are enrolled family members will become "qualified beneficiaries" if their coverage would otherwise end due to one of the following qualifying events:

   - The Retiree dies;
   - The Retiree's divorce or legal separation;
   - In the case of a child, he or she is no longer an eligible disabled dependent child under the Plan.

2. **Notices and Election Rights.** COBRA coverage is available under the Plan to qualified beneficiaries only after the Retiree's Group and HealthTrust have been notified that a qualifying event has occurred. The Retiree or an eligible family member who is a qualified beneficiary must notify the Group Benefits Administrator within 60 days of the date coverage under the Plan would otherwise end due to divorce, legal separation or a child losing eligibility status under the Plan. Failure to provide such notice within this 60-day notice period will result in any eligible family member who loses coverage not being offered the right to elect continuation coverage. Once the Group is notified of the qualifying event, the Group will then notify HealthTrust.

   After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of the right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the **later of** the following dates to make their elections:

- 60 days after the date their coverage would otherwise end due to the qualifying event; or
- 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

3. **Duration of COBRA Coverage.** COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage is 36 months if the qualifying event is the Retiree's death, divorce or legal separation, or a child losing disabled dependent child status.

   - **Additional Coverage Continuation Rights Upon Death of a Retiree**. In addition to the COBRA continuation rights under federal law, in certain circumstances continuation of coverage under the Plan also may be available to the surviving spouse and/or disabled dependent child of a Retiree after the death of the Retiree in accordance with applicable Retiree coverage rules of the Group and HealthTrust. Please contact the Group Benefits Administrator for further information.

     Please note: The Plan does not provide additional continuation coverage rights to former spouses under NH RSA 415:18, VII-b.

     COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under COBRA law. Eligibility for COBRA coverage under the Plan will end if the Retiree's Group terminates participation in the Plan for its active employees.

4. **Cost of Continuation Coverage**. Eligible qualified beneficiaries will be obligated to pay the full premium costs for COBRA or other continuation coverage unless the Retiree's Group has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium costs and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.

For more information regarding COBRA and other continuation coverage rights and obligations, please contact the Group Benefits Administrator or HealthTrust, or refer to the COBRA information document provided upon initial enrollment. If You would like a current version of the COBRA initial notice, please contact HealthTrust.

SECTION 11: DEFINITIONS

This Section defines some of the specially capitalized words and phrases found throughout this Certificate.

Please consult Your Medicare Benefits Handbook for the definitions of words and phrases used by Medicare. For information about Medicare, go to www.medicare.gov on the web, select "Forms, Help, & Resources." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Adverse Benefit Determination means the Plan's denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for coverage under this Certificate. Adverse Benefit Determination also includes the Plan's denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review procedures, as well as the Plan's determination not to cover an item or service for which Benefits are otherwise provided based on a determination that the item or service is Experimental, Investigational or not Medically Necessary or appropriate, as well as a rescission of coverage.

Ambulatory Surgical Center for purposes of Major Medical Benefits means a facility licensed as an Ambulatory Surgical Center as required by law that satisfies our accreditation requirements and is approved by Anthem.

Anniversary Date means the first day of the Group's Plan Year. The Anniversary Date is January 1 for Groups with a January Plan Year and July 1 for Groups with a July Plan Year.

Anthem means Anthem Health Plans of New Hampshire, Inc., doing business as Anthem Blue Cross and Blue Shield, which is licensed in the State of New Hampshire as a third party administrator. HealthTrust has contracted with Anthem to provide certain services, including claims processing, administration and utilization management services, for this health care Plan.

Behavioral Health Care for purposes of Major Medical Benefits means Covered Services provided to treat Mental Disorders and Substance Use Disorders as defined in Section 4, V, "Behavioral Health Care (Mental Health and Substance Use Care)."

Benefit(s) means reimbursement or payments available for Covered Services, as described in this Certificate.

Birthing Center means an Outpatient facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide Outpatient facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn. To be eligible for Benefits under this Certificate, a Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no Benefits are available for services furnished by a Birthing Center.

BlueCard Provider for purposes of Major Medical Benefits means a Provider outside New Hampshire that has a written payment agreement with the Local Plan.

Certificate means the Plan Document which describe the terms and limitations of coverage under this health care Plan. The Certificate includes the Subscriber Certificate (this document), Your Medical Enrollment Application, Your identification card, and any endorsements, riders or amendments to the Subscriber Certificate.

Community Mental Health Center for purposes of Major Medical Benefits, means a licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963, or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.

Covered Service(s) means the services, products, supplies or treatment specifically described as being eligible for Benefits in this Certificate. To be a Covered Service for Medicare Complementary Benefits, the service, product, supply or treatment must meet the requirements established by Medicare.

To be a Covered Service for Major Medical Benefits, the service, product, supply or treatment must be:

- Medically Necessary or otherwise specifically described as a Covered Service under this Certificate;
- Within the scope of the Provider's license;
- Given while You are covered under this Plan;
- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Certificate; and
- Provided in accordance with the Plan rules stated in this Certificate. Otherwise, a service may not be a Covered Service.

Developmental Disabilities for purposes of Major Medical Benefits, means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, but are not limited to, abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Diabetes Education Provider for purposes of Major Medical Benefits, means a certified, registered or licensed health care expert in diabetes management who furnishes diabetes counseling and diabetes education to Members.

Experimental or Investigational for purposes of Major Medical Benefits, means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be experimental or investigational as defined in Section 5, I.

Group means any New Hampshire municipality, county, school district, or other political subdivision or instrumentality thereof which is a member of HealthTrust and is offering health care coverage under this Plan to its eligible Retirees and eligible family members of Retirees. Your Group is the Retiree's former employer.

Group Benefits Administrator means the person at the Retiree's former place of employment who handles health plan benefits for Your Group.

HealthTrust means HealthTrust, Inc., a New Hampshire voluntary corporation.

Home Health Agency for purposes of Major Medical Benefits means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

Inpatient means care received while You are a bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility.

Intensive Outpatient Program for purposes of Major Medical Benefits, means structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three hours per day, three days per week

Local Plan means the Blue Cross and Blue Shield Plan in the geographic area where You receive Covered Services (outside the Service Area).

Major Medical Benefits means those Benefits provided under this Certificate that are in addition to the Medicare Complementary Benefits. Major Medical Benefits are generally Benefits for:

- Services that exceed a Medicare Eligible Expense maximum or limitation
- Medicare Part B Excess Charges
- Services that are not paid or payable by Medicare

Major Medical Benefits are described in Sections 3, 4 and 5.

Maximum Allowed Amount for purposes of Major Medical Benefits means the maximum amount of reimbursement the Plan will allow for Covered Services. For more information, see Section 6, I, "Maximum Allowed Amount."

Medical Child Support Order means, in accordance with New Hampshire RSA 161-H:1, any valid judgment or order to provide health coverage for a dependent child of the Subscriber issued by any court or administrative body of the State of New Hampshire or any other state including an order in a final decree of divorce.

Medical Director means a physician licensed under New Hampshire law, employed by Anthem, and responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medical Enrollment Application (Application) means the application form that must be completed, signed and submitted to the Group Benefits Administrator. An applicant is enrolled under the Plan only upon acceptance of the Medical Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in membership and enrollment information.

Medically Necessary or Medical Necessity for Medicare Complementary Benefits is determined by Medicare. Medically Necessary for Major Medical Benefits means health care services or products provided to a Member for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Member or the Provider.

Please note: The fact that a Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Benefit Determinations regarding Medical Necessity. Please refer to the appeal process in Section 8 of this Certificate for complete information.

Medicare means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Medicare Benefit Period means the period of time used by Medicare to measure Your coverage under Medicare Part A. Your first Benefit Period begins on the day You enter a hospital as a Medicare patient. It ends 60 days after You leave the hospital (counting the day of Your discharge) or, if You have to go from the hospital to a Skilled Nursing Facility, it ends 60 days after You leave the Skilled Nursing Facility. If You are hospitalized again within 60 days, the second hospital stay is considered part of the first Benefit Period.

Medicare Part A or Part B Coinsurance means that portion of the health care charges that You are required to pay after the applicable Medicare Part A and Part B Deductible is met.

Medicare Complementary Benefits means those Benefits that are complementary to Medicare Eligible Expenses. Medicare Complementary Benefits generally satisfy those amounts that remain after Medicare has made payment for Medicare Eligible Expenses, for example Medicare Part A and Part B Deductibles and Medicare Part A or Part B Coinsurance. Medicare Complementary Benefits are not available for services You receive that are not eligible for payment under Medicare. Medicare Complementary Benefits are described in Section 2.

Medicare Eligible Expenses means expenses for services that are paid or payable by Medicare.

Medicare Part A or Part B Deductible means the amount of health care charges Medicare requires You to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B Excess Charges means the difference between the actual Medicare Part B billed charge and the Medicare allowed Part B charge for non-assigned claims. The billed charges must not exceed any limitation established by Medicare or state law.

Member means the Subscriber covered under the Plan.

NonBlueCard Provider for purposes of Major Medical Benefits means a Provider outside New Hampshire that does not have a written payment agreement with the Local Plan.

Nonparticipating Provider for purposes of Major Medical Benefits means any Provider that is not a Participating Provider.

Outpatient means any care received in a health care setting other than an Inpatient setting ("Inpatient" is defined above).

Partial Hospitalization Program for purposes of Major Medical Benefits, means a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six hours per day, five days per week.

Participating New Hampshire Certified Midwife (NHCM) for purposes of Major Medical Benefits, means an individual who is certified under New Hampshire law and who has an agreement directly with Anthem or with the Local Plan to provide Covered Services to Members.

Participating Provider for purposes of Major Medical Benefits, means a Provider who has a written agreement with Anthem or with its Local Plan to provide Covered Services to Members. A Provider that is participating for one Plan may not be participating for another.

Physical Rehabilitation Facility for purposes of Major Medical Benefits means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Plan means HealthTrust's Medicomp Three health care plan, as described in this Certificate, which is offered by the Group to eligible Retirees. The Plan is also offered to eligible family members of a Retiree.

Plan Year means the twelve month period selected by Your Group for its participation in the Plan. Each Group will select either a January (January 1 through December 31) or July (July 1 through June 30) Plan Year. The initial Plan Year for each Group will be the period beginning with the first of the month in which participation in the Plan begins and ending with the next December 31 or June 30, depending on whether the Group selects a January or July Plan Year. Thereafter, the Plan Year will be each successive twelve-month period.

Post-Service Claim means any claim for a Benefit for which terms of the Plan do not condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Post-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Pre-Service Claim means any claim for a Benefit under the Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. "Pre-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Prior Approval for purposes of Major Medical Benefits means the process by which You or Your Provider may request that Anthem review proposed services to determine if services are Covered Services.

Private or Public Hospital for purposes of Major Medical Benefits, means a licensed Private Psychiatric Hospital or Public Mental Health Hospital that provides diagnostic services, treatment and care of acute Mental Disorders under the care of a staff of physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.

Provider means a healthcare professional or facility that is duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the applicable scope or license or certification, and is approved by Anthem. Providers of Covered Services are described throughout this Certificate. If You have a question about a Provider not described in this Certificate, please contact Anthem Member Services at the number on Your identification card.

Psychiatric Advanced Practice Registered Nurse for purposes of Major Medical Benefits, means a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing

Residential Treatment Center for purposes of Major Medical Benefits means an inpatient facility that treats mental health and substance abuse conditions. The facility must be licensed as a residential treatment center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center does not include a Provider, or that part of a Provider, used mainly for any of the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic means a facility that provides care for limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Health care services are typically provided by physician assistants or Advanced Practice Registered Nurses. Services are limited to routine care and treatment of common illnesses for adults and children.

Retiree means a person who is retired from active employment with a Group and who the Group determines is eligible to continue coverage under the Plan or another health plan offered by the Group, pursuant to NH RSA 100-A:50 and/or applicable HealthTrust and Group rules governing eligibility for Retiree coverage.

Service Area means the State of New Hampshire, and also includes certain cities and towns in counties of Maine, Massachusetts and Vermont that are contiguous with the New Hampshire border.

Short Term General Hospital means a health care institution having an organized professional and medical staff and Inpatient facilities which care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Skilled Nursing Facility for purposes of Major Medical Benefits means a facility licensed as a skilled nursing facility in the state in which it is located that satisfies Anthem's accreditation requirements and is approved by Anthem. A Skilled Nursing Facility is not a place mainly for care of the aged, custodial care or domiciliary care, or a place for rest, educational, or similar services.

Subscriber means the individual who is properly enrolled and accepted for coverage under the Plan.

Substance Use Disorder Treatment Provider means a facility that is approved by Anthem and which meets the following criteria: is licensed, certified or approved by the state where located to provide Substance Use Disorder rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by The Joint Commission (TJC) on Accreditation of Hospitals as a Substance Use Disorder Treatment Provider.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize Your life or health or Your ability to regain maximum function, or
- In the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the proposed care or treatment.

Urgent Care Facility means a licensed health care facility whose main purpose is providing immediate, short-term, urgent health services for diagnosis, care and treatment of illness or injury. An Urgent Care Facility may be free-standing or a facility located in the Outpatient department of a hospital.

Walk-In Center means a licensed free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of illness or injury.

Year means a calendar year, unless specifically stated otherwise. A calendar year starts on January 1 and ends on December 31 in any given year.

You or Your means You, the person to whom this Certificate is issued (the Subscriber), unless specifically stated or where the context provides otherwise.

HealthTrust Notice of Privacy Practices

Protecting Your Health Information is Important to Us.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that HealthTrust inform you of our privacy practices regarding your protected health information (PHI). We are fulfilling that requirement with this Notice, which applies to our medical and dental plans, as well as services provided for healthcare flexible spending accounts and health reimbursement arrangements. This Notice does not apply to our short-term disability, long-term disability, and life coverages, however protecting all personal information is important to us.

Uses and Disclosures

This section describes how we typically use or disclose your protected health information (PHI).

For Payment Activities: We may use or disclose your PHI for billing and payment (for example, by providing an invoice or information to your participating employer group to collect premiums or confirm coverage for those billed on the invoice).

For Treatment: While HealthTrust does not provide treatment, we may use or disclose your PHI for the coordination of your healthcare coverage (for example, by confirming your coverage with a treating physician).

For Healthcare Operations: We may use or disclose your PHI for the administration of your health plan coverage or quality improvement initiatives. For example, we may share enrollment information or summary information related to the creation, renewal, or replacement of your health benefits with your participating employer group. Enrollment information may include information you would be asked to provide to your participating employer group upon enrollment and any updates to that information. Further, in administering HealthTrust medical and dental plans, HealthTrust will not disclose information to an employer about individual claims or diagnosis unless permitted by a written authorization or otherwise required or permitted by law.

To Business Associates: We may disclose your PHI to our Business Associates, who assist with our operations and have provided written assurance that they will safeguard your information (for example, by sharing eligibility information with the claims administrator).

To Other HIPAA Covered Entities: We may disclose your PHI to other HIPAA covered entities that have a relationship with you (for example, to a medical provider who is treating you).

For Plan Administration: We may disclose certain information to the Plan Sponsor provided they have agreed to safeguard PHI. For example, if your employer group contracts with us to assist in administering its healthcare flexible spending account plan, we may share your information with them for administration of that plan.

As Required by Law or Authorized for Oversight Activities: We may use or disclose your PHI when required by law or authorized by law for public health and public benefit oversight. Examples may include to comply with a court order, to avert an imminent threat to health and safety, for regulatory oversight by federal or state authorities, for research purposes, or as authorized by workers' compensation laws.

Upon Your Authorization: We will not use or disclose your PHI other than described here, or as permitted under applicable laws, unless you provide written notice authorizing the use or disclosure. You may revoke the authorization at any time.

In certain situations, you can also tell us your preference about disclosure of certain information - for example, sharing information with family or friends involved in payment for your care or sharing information in a disaster relief situation or medical emergency. However, if you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Your Rights

This section describes your rights regarding the protected health information we maintain.

Inspect and Copy: You can ask to inspect or copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.

Amend: If you think your records are incorrect, you can ask us to amend them. We are not required to honor this request, but must respond within 60 days.

Confidential Communication: You can request we contact you in a specific way or send mail to a different address. We will consider all reasonable requests.

Restrictions: You can request we not share certain PHI for treatment, payment, or healthcare operations; however, we have the right to say no to the request.

Accounting of Disclosures: You can request a list of disclosures of your PHI made for reasons other than treatment, payment, healthcare operations, or made to you or with your authorization.

Copy of this Notice: You can ask for a paper copy of this Notice at any time.

Personal Representative: If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights on your behalf.

File a Complaint: If you believe that we have violated your privacy rights, you may file a complaint in writing with the HealthTrust Privacy Officer. You may also submit a complaint with the Office for Civil Rights of the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Our Responsibilities

This section describes our responsibilities related to your protected health information.

Safeguard Your Information: We are required by law to protect your health information, and will follow the duties and privacy practices described in this Notice.

Notification: We will alert you promptly if a breach occurs that may have compromised the privacy or security of your PHI.

Minimum Necessary: When using or disclosing your PHI we will make reasonable efforts to use or disclose the minimum amount of information needed to accomplish the intended purpose. Some disclosures such as those made to you, the US Department of Health and Human Services, or as required by law are not held to the minimum necessary standard.

Marketing, Sales, and Fundraising: We do not use, disclose or sell your PHI for any marketing, sales, or fundraising activity, nor would we do so without your written authorization or as permitted by applicable law.

Genetic Information. We do not use or disclose genetic information for underwriting purposes.

Psychotherapy Notes: We do not maintain any psychotherapy notes. If our Business Associates have these notes, they will not disclose them without your written authorization.

If you have any questions, need further information regarding this Notice, or if you wish to receive another copy, please contact:

Privacy Officer
HealthTrust, Inc.
PO Box 617
Concord, NH 03302-0617
800.527.5001 (Toll-Free) 603.226.2861 (Local)
privacyofficer@healthtrustnh.org

HealthTrust can change the terms of this Notice, and the changes will apply to all protected health information we have about you. The current version of the Notice is available on our website at *www.healthtrustnh.org*. This Notice is effective as of July 1, 2019 and replaces HealthTrust's previous Notice dated January 12, 2015.

It’s important that Anthem treats you fairly

That’s why Anthem follows federal civil rights laws in our health programs and activities. Anthem does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, Anthem offers free aids and services. For people whose primary language isn’t English, Anthem offers free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think Anthem failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf . Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language

Curious to know what all this says? Anthem would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)